

Conflicts of interest in the distribution of health resources

Conflictos de interés en la distribución de recursos en salud

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Abstract

Conflicts of interest in the distribution of health resources need to be clarified and regulated with bioethical principles of justice, in other words, specified in terms of equity, utility, and care for the most vulnerable. In this way, it becomes possible for the interest of the public, rather than other types of interests, to triumph in matters of distribution. As a result, situations of partiality in the implementation of policies of distribution or in the selection of patients who are to receive scarce resources are avoided. This is a need in particular in countries such as Mexico, where there is a great deal of social injustice, embodied in several social determinants of health. This article aims to offer insightful principles for justice in the distribution of health resources.

Keywords: justice, equity, utility, vulnerability.

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Introduction

Health resources are the means of any kind that serve to provide both public health and health care services. They can refer to those used in public or private medicine (1). Every human being makes use of various health resources to care for their health, and without these the achievement of it would be unthinkable.

However, distributing resources is an unavoidable task, since these are limited anywhere in the world. It is the task of a government to carry out a distributive task of public goods so that citizens can enjoy the opportunity to achieve health. In order to exercise good governance, this task must be done in an equitable, efficient or useful way and that it prioritizes the most vulnerable;¹ that is, in accordance with fairness (2).

However, the distribution of resources is not carried out in a neutral or aseptic way. It is subject to various interests, for example, benefiting the person with whom you have a relationship of interest, such as kinship, friendship or moral ancestry; or prioritize with certain resources those who are economically worse or those who are in a worse situation of health (3), depending on the ideology or political interest that the resource distributor may have.

Conflicts of interest are those situations in which the judgment of a subject and the integrity of his actions tend to be unduly influenced by another interest, which is often of an economic or personal nature (4). Interests are part of life: everyone proceeds in an interested way when looking for what is necessary for his/her fulfillment and well-being, which does not entail any ethical fault. The problem is when such interests compete with the primary interest. Then there is a conflict of interest secondary to the service of the individual or a certain purpose, and the primary one that must be the service to the health of people.²

Conflicts of interest should be oriented in order to clarify what is correct. Justice is the greatest of virtues (5), and although it has

several specifications according to the theory of fairness that is invoked, fairness, efficiency and to look after the most vulnerable, help to avoid conflict of interest, by guiding in the right sense when making a decision that can be clouded by the secondary interest that everyone has.

The objective of this work, is to show some conflicts of interest that can occur in the distribution of health resources in light of three principles or specifications of fairness: equity, efficiency and seeing for the most vulnerable.³ For this, the importance of fairness in the distributive task will be made clear, through the aforementioned principles.

Next, certain distributional issues of importance for Mexico and countries that face great social injustice will be discussed, such as: the fulfillment of the right to health care; the definition of the item for health care, the priorities in the health services, and the model of the health system; and the fair choice of subjects before scarce treatments. Some conflicts of interest that may occur when exercising the distribution of resources will be shown, both at the level of design of institutions or policies and at the level of choice among patients.

The main agents responsible for the distribution of health resources will be appealed: the State as the main guarantor of this right to health and healthcare and limiting benefits; health institutions, direct managers of care, which must combine efficiency, equity and privilege the vulnerable; and lastly, health professionals, true final distributors of resources (6).

Situations that disapprove of all ethical standards in justice and that have to do with corruption are not addressed here. For example, the production, possession, trafficking or proselytizing and other acts in the field of narcotics (7, Arts. 193-199), or crimes for acts of corruption such as abuse of authority or illicit enrichment (7, Articles 215 and 224), which disapprove of any principle of justice.

1. The distribution of resources and their relation to justice

Designing the scope of basic healthcare institutions involves distribution decisions.⁴ Now, the important thing is that it must be done in order, that is, under certain reasonable criteria.⁵ Such order is required since the distribution can be made partially, or under interested criteria, giving reason for conflicts of interest.

What is sought is to determine the following: What kinds of health care services should there be in one place? Who will receive them and on what basis? Who will distribute them? How will your financing charges be distributed? How will the coordination of these services be distributed? (9). These distribution decisions have to do with the economic funds, with the amount and type of health care to be distributed, and with the type of problems that are intended to be solved.

Neither the free market, nor technology, nor new governments, nor the hoarding of natural resources... nothing can avoid limits on resources. And the same is true in the field of health. No one can have all the healthcare they want, because it is limited and shared with others. Nor can unlimited resources be devoted to health care because other areas are neglected. The greater the budget a State dedicates to health care, the lesser it can allocate to other goods and services, such as education, security, housing, etcetera.

Conflicts of interest are those situations in which the judgment of a subject, in relation to a primary interest for him or her, and the integrity of his actions, tend to be unduly influenced by a secondary interest, which is frequently economic or personal type (4). Or when professional responsibilities diverge from personal interests (9). The desire to earn money, increase reputation, obtain political favor or only to improve self-esteem are common reasons for scientific malpractice because they cause conflicts of interest, that is, conflicts with the scientific standards of the search for true knowledge. In the case of the distribution of resources, it could be

said that the desire to earn money or to gain political favor may prevail, postponing what is mandated by the distributive ethical criterion.

In the latter lies one of the main contributions of justice. Because the rationing of health resources is a task that cannot be postponed anywhere, justice must offer normative criteria so that this task is done in an orderly manner, that is, in a fair way. For example, the economic globalization characteristic of the expansion of the free market in a universal way has resulted in an overabundance of resources in a few people and a shortage of resources in the vast majority of the earth. The danger is that this system will expand more and more in the health sector, through market medicine, with efficacy and economic performance prevailing over other more equitable ethical criteria or of prioritizing the most vulnerable.

Now, knowing what is fair or the content of justice must be given by that theory that is considered ideal for distributing resources (9, 11), taking into account, for the purposes of this chapter, the three central ones in Western philosophical ethics: the Aristotelian, the Kantian and the Utilitarian, whose central principle can be specified as: «give each person what he is entitled to», «treat everyone with equal consideration and respect», or «seek the greatest utility for the greatest number» (12). In reality, all three are important, because they highlight key elements for a fair distribution: equity, the rights of people beyond their socio-economic level and efficiency.

Each of these principles has different concretizations depending on the circumstances. In the case of giving each one his due, equality is measured according to medical needs, which gives rise to the famous criterion «equal cases, equal treatments; different cases, different treatments». That is, in the face of the same disease, the same treatment should be given. But it would be contrary to the principle if, for economic or educational inequality, two pa-

tients with the same medical need one is better treated than the other one.

From the Kantian principle «treating everyone with equal consideration and respect», John Rawls' theory of justice through a procedural and democratic methodology reaches three central principles for the distribution of resources: 1. Civil liberties are governed by the principle of equal freedom of citizenship; and 2. The assignments and positions must be open to all, in accordance with the principle of fair equality of opportunity. But it also adds the difference principle, by which the unequal distribution of these goods is only fair if it obeys the «maximum» criterion, that is, if no other way of articulating social institutions is capable of improving the expectations of the least favored group (13). With this, two key principles for an equitable distribution of resources are clear: fair equality of opportunities (14) and the duty to prioritize the most disadvantaged (13, 16).

Economists' own need for efficiency is championed by the principle «the greatest utility for the greatest number». From here derive the criteria for prioritizing patients in favor of a resource according to the utility it will represent. The analysis programs of cost minimization and profit maximization will be decisive. However, the conflict of interest can emerge when only these criteria are used, which can leave the least advantaged without adequate attention, for example, the elderly or those who will take less advantage of the resource because they have less health.

The aforementioned must also be seen from a justice perspective that is not limited to the health field, but rather takes into account the social, cultural or environmental factors that make a person or a population sick, the social determinants of health. (SHD), widely considered by theories of social justice (15, 16). In places of high injustice such as Mexico, not considering the macro factors that predispose subjects to become ill, can lead to committing more injustice with those who have the least. For example, when considering equal cases and giving equal treatments for refe-

ring patients with the same clinical entity, without taking into account what factors such as economic or cultural poverty influence in the non-adherence to treatment of one of them.

Below are some topics on the distribution of resources and certain conflicts of interest that may arise. The former are at the structural level or of a macro distributive character level, and the latter at the patient or micro distributive level. In macro-distributives, there is a danger that decisions, based on statistics or numbers, or referring to institutions, will relativize conflicts of interest or the impact of what has been decided. In the micro distributive conflicts of interest occur in doctors or health professionals who distribute resources among specific people, the decisions involved are more drastic, and therefore, reveal more the need for impartiality in distribution. Both call for awareness and education on justice matters.

2. Some topics that require fair administration of healthcare and possible conflicts of interest

a) Rights to the sanitary assistance

In the first place, health is above all a public good, a human right whose protection must be safeguarded by the State. It is a human right to protect health and guarantee the right to well-being or social security (17, Arts. 22 and 25). The International Covenant on Economic, Social and Cultural Rights contains the most exhaustive article of international human rights law on the right to health. Under article 12, paragraph 1, of the Covenant, States Parties recognize «the right of everyone to the enjoyment of the highest attainable standard of physical and mental health», while article 12, paragraph 2, indicates, by way of an example, various «measures that the States Parties must adopt in order to ensure the full effectiveness of this right». The right to health is related to other rights,

such as work, education, housing, etc. Furthermore, it takes into account the SDH as determining factors for the satisfaction of the right to health (18).

Notwithstanding the foregoing, the right to health care is still far from being universally fulfilled. Nearly half the world's population lacks comprehensive access to basic health services, and close to 100 million people are forced into extreme poverty (living on \$1.90 a month or less) because they have to pay for health services out of pocket (19). Realities like these sometimes occur in places with an abundance of resources, but concentrated in a few hands, such as Mexico, Brazil or India. In Mexico, there is talk of health coverage for a set of services of 89.3%, which is far from being sufficient. When coverage is specified for all services, the amount drops to 52%, and for hospital care it is 66%. Dental care coverage is 7%. On many occasions, private medicine is used due to insufficient attention in public medicine (20). The principles of equity and privileging the most vulnerable would ask to make a strategic path to attend the right to health care.

Outside the health field there are other reasons that cause and have as a consequence a great injustice in the distribution of health care. This is the SDH (21). For the World Health Organization (WHO), the economy influences health in many ways. The distribution of goods such as land and other forms of production, and opportunities such as education, outline health patterns. Factors such as poverty, illiteracy, hygiene, habitat... and the health-disease binomial are closely related, in such a way that working on removing poverty or giving education has a positive impact on the health of a population and vice versa. For example, supplementing and stimulating infants with delayed growth has been shown to have a direct impact in their favor. Investing in the first years of life is one of the measures that is most likely to reduce health inequalities within a generation (21). Prioritizing the most vulnerable will require addressing SDH.

b) Expenditure or item intended for health care

Secondly, the item for health care is another item of great importance since it depends on the fact that, in part, the right to health care can be fulfilled. Charles Fried (22) argues that there is a decent minimum of obligation to provide health care from the State to its citizens. It does not specify what services or how much attention, but rather enough to guarantee that the basic needs of the individual are met, with the rest being in charge of the market. It states that the decent minimum would concentrate what is necessary for a bearable life, but, at the same time, it does not offer a clear definition of this concept either, but maintains that it is each society that must define it based on the economic balance in terms of cost benefit and a decision on what the community is willing to spend on health. Allen Buchanan supports the decent minimum thesis, but does not consider the problem in terms of law, but raises it as an act concerning the charity or charity of society; it is a collective effort, compulsory and coordinated by the State (23).

A goal higher than the decent minimum and that has more to do with the guiding principles of justice in this work is Universal Health Coverage (UHC), a term that WHO has adopted since the 2005 General Assembly and has firmly hoisted in the 2010 World Health Report. This is achieved when all people receive quality services for their health care without it representing a financial problem by having to pay for it. According to the WHO, the distribution of resources must be guided by equitable policies that better distribute resources, by efficient policies that improve the performance of services, and by liberal policies that encourage payment for services to the extent of the patient's abilities, but especially that they avoid the disbursement for the payment of health in private medicine. This will involve expanding high-priority services, including more people, and reducing out-of-pocket costs⁶ (24). Thus, the principle of privileging the most vulnerable is fulfilled.

The UHC will depend on the budget allocated to healthcare. In Mexico, a very low budget is assigned to this item, compared to the Organization for Economic Cooperation and Development (OECD). In Mexico in 2016, health expenditure per person was 1,080 dollars, a quarter of the OECD average. Another consequence of the low investment in health care is the high out-of-pocket expenditure that in 2017 was 41 percent and in 2019 it is reported above 40 percent of health spending, compared to 20 percent of the OECD (20, 25). This has repercussions for the poorest in delaying medical care or in a 3-fold increase in their unmet medical needs compared to the wealthy (20).

c) Priorities in the healthcare system

Third, a primary task in the delivery of health care is to set priorities in the health care system. It can be expressed through the question: how to divide the portion of the budget dedicated to health care, among the various services and institutions? It has a lot to do with responding, what kind of needs and in what order of priority the healthcare system should address them.

In the selection of priorities, the goal will be to achieve the UHC, under criteria of equity, effectiveness, and preference of the most vulnerable. In high-income countries, priorities have been discussed mainly in relation to costs, new technologies, and age, trying to be equitable and efficient. In medium and low-income countries, the discussions have to do with prioritizing the research and treatment of those diseases that cause the greatest health burden (25, 26) and the appropriate prioritization of services according to public health needs, generally suffered by the most vulnerable.

From the perspective of WHO, an adequate selection of priorities must take into account the UHC (24). The first priority of all countries should be in primary care, regardless of whether this calls for the redistribution of responsibilities and even the revision

of the power structure. This implies important challenges of financial and political management on the part of the State. However, the ultimate goal must be to achieve UHC.

Regarding the necessary prioritization in prevention, it must be taken into account that treatment costs are ordinarily much higher than preventive ones. Preventive medicine is more efficient in terms of containing health costs, reduces suffering especially due to chronic conditions, and increases health levels, especially in primary care (28). In addition, how a society can appropriately combine preventive and treatment strategies will depend, in part, on knowledge of causal connections, such as those between disease and environmental and behavioral factors such as SHD. Prevention has a lot to do with addressing the vulnerability of the most disadvantaged.

UHC policies must ensure that people adopt healthier lifestyles. In middle- and low-income countries, large social groups face greater difficulties than others in choosing their lifestyle, due, for example, to low incomes that determine the place and way of life of people. Furthermore, many social groups are at greater risk of adopting behaviors that harm health, such as overwork to achieve a barely sufficient income. A special reorientation of health education and disease prevention is necessary, bearing in mind that traditional health education programs have typically been less successful in impacting vulnerable and most needy groups, particularly by blaming them for their own poor health.

Another decision corresponds to the distribution of resources and medical facilities according to the geography of each country. Access inequalities also arise when resources and facilities are not well distributed throughout the country, being clustered in urban or prosperous areas and being scarce in rural or depressed areas (20). Because depressed communities tend to suffer the worst health conditions, this uneven distribution means that medical services are less accessible where they are most needed.⁷

It is worth mentioning that in places where health care is divided into primary, secondary, tertiary and highly specialized, the resources allocated to each class must be provided according to the amount of population that uses them, prioritizing primary care and preventive medicine, under the criteria of efficiency and equity.

d) A model of a health care system

Finally, the model of the health care system is also the object of the administration of public goods. Between two extreme models of health care, the practice has been designed and experimented to meet the health needs of the population: unified systems and pluralistic systems. The former, also called «monopolistic», typical of countries such as Cuba, Venezuela and, to a lesser extent, Costa Rica, have taken into account above all egalitarian justice, with a secondary consideration of usefulness. It would represent a universal healthcare model under a single command and financed by taxes. All citizens are covered by a unified national system without reference to age, social status, medical condition, or employment status.

The opposite model, also called «atomized private», is one in which citizens receive health services from both public and private providers. Financing is by consumer disbursement or through multiple private insurance agencies. Towards this model, the aim has been to migrate the Mexican health system in past administrations, leaving to the State the mere administration of a series of health service providers.

Between these two there are intermediate models, the public contract system, which is typical of Brazil, and the segmented system, as is the case in Mexico. The latter's health system is not as efficient as it should be, among other reasons because public health institutes are separated and disconnected from each other, or because of the segmented way of organizing health care between agencies for beneficiaries, institutions for general public and

private medicine, which causes unequal attention due to the cost and difficulties of access it shows, inefficient due to the duplicated use of available resources and poor use of its technical capabilities (30). All of the above asks the health authority for regulatory work that must be carried out.

e) Conflicts of interest in healthcare administration

The administration of health care under the previous topics may be a reason for conflicts of interest. The clarity for a correct choice is given in light of the moral principles of equity, efficiency or usefulness and privilege of the most vulnerable, which guide what can be done in the search for a fairer distribution of resources.

A conflict of interest can arise in a government between its duty to administer public goods efficiently and equitably and the neglect or abandonment of this work. Thus, for example, the State's non-compliance with human rights occurs by putting other types of priorities before it, such as spending on weapons or giving high bills to popular representatives and their parties, at the expense of reducing, among others, health spending. This has happened in Mexico for a long time, justifying the authorities that through the Popular Insurance or currently the Institute for Welfare, the UHC will be fulfilled (31).

In controversies over the budget line for health care, competition between the lines may be only political and without moral criteria, showing a conflict of interest between achieving the purposes of a certain group in power versus the general interest of satisfying a certain need of the population. A budget determination for existing items on an ethical basis would entail adhering to morally fair procedures (32), that reflect equity, efficiency, and priority for the most vulnerable.⁸

If a society does not allocate sufficient funds to provide the UHC, the system itself will be far from fair. Failure to do so denotes a frank conflict of interest between the State's duty to provide

basic health care and the breach of this right for various reasons that cannot be superimposed on a basic human right.

Complying with the standard of giving a sufficient start to the health sector does not guarantee that it will be used correctly, since its institutions may function inefficiently or wastefully in the use of resources. Likewise, corruption in the use of budgeted money undermines any purpose of fair administration of resources for the health sector and directly affects any attention in favor of the most vulnerable. As stated, it disapproves of all ethical standards. But in the same way, making indiscriminate cuts to health care, for the sake of eliminating the flawed and with the intention of distributing it, speaks of lack of efficiency and is therefore equally unfair. Therefore, in addition to granting the sufficient amount, it is necessary to implement mechanisms of strategy, supervision and vigilance, proper to accountability, to avoid misuse or to optimize the good use of existing resources and to take care that the most vulnerable sectors be served.

Conflicts of interest in the definition of health priorities have to do with the disinterest of the health authorities in the priority of public health, which leads to excessive expenses, for example, in the emergency services with respect to the low investment in preventive medicine; to allow excesses in investigating alleged treatment novelties versus investigating the causes of disease (33); excessive spending on advertising and shortages in primary, family and community care, etcetera.

In relation to the health system model, the segmented system distinguishes between the poor and the population with the capacity to pay; between the formal sector of the economy that is insured and the classes not covered by social security. In its configuration lies its main ethical inconsistency and a latent conflict of interest: to tolerate absolute inequalities in health care or its quality, and to be inefficient by duplicating similar functions performed by different sectors.

It is not a matter of migrating to unified systems, which are also subject to various criticisms (34). It is a matter of ensuring that the chosen model of the health system ensures the UHC, for which the intervention of the State will be essential in order to guarantee that the market does not obstruct social goals, such as equity. If there is no effective supervision of health service prices, and if competition between providers fails to keep prices low or high quality, poor and vulnerable populations will suffer from lack of adequate and equitable access to health care. .

Starting from equity, efficiency and looking for the most vulnerable, typical of justice, absolute inequality of access and quality unevenness imply lack of justice, by attacking the UHC.

«It is not clear what policy a government should follow. Justice considerations by themselves do not give a clear answer. But they show that absolute inequality of access and quality unevenness are unfair and immoral under Rawls' theory of justice, Hare's utilitarian version, or the communitarian vision of respect for people. Since these three theories of justice converge on this point, it would not be unreasonable for them to illuminate regulatory legislation...» (35, p. 20).

Finally, another possible source of conflicts of interest has to do with the segmented model of health care, in which the doctor often works at the same time in public and private medicine, making improper use of the former. In public hospitals, whether in social security or public health care, there are a series of limited resources before which users have to wait long times due to the saturation of services and the lack of investment in infrastructure. However, it is known the medical practice of «putting» patients at their discretion, for being «recommended», to diagnostic or therapeutic procedures that would be very expensive in private medicine, lengthening the long waiting times of users. The doctor working in public health should clarify to his private patients that under no circumstances can he make such exceptions. In places of such inequality as Mexico, which strongly affects access to health

care, the health professional should be aware that whoever can pay for private care must do so, or, failing that, respect the rules of public medicine.

3. Assign scarce treatments for patients and possible conflicts of interest

Within the micro-distribution, the reflection will focus on the distribution of scarce therapeutic resources. It is an inescapable issue on which doctors make decisions, perhaps often little aware of the ethical implication that it entails, driven by different criteria such as medical necessity, urgency of treatment, usefulness, etc. They are usually taken in secret and there is difficulty in making them public due to the conflict that they entail, since nobody likes to be rationed a resource (36). All in all, the *triage* system is a valuable ethical resource that has been established in the outpatient clinic and in the emergency services for the distribution of health resources in both public and private medicine.

The question that best defines this level is: which patient is the available therapeutic resource? Or in harsher terms: who should be saved when everyone cannot be saved? Making decisions is more difficult when a disease threatens life and the scarce resource is potentially capable of saving the patient.

Micro-distribution decisions are affected by the right to UHC under the principles of equity and utility, but not by preferential attention to the vulnerable, at least directly. In the face of two patients who need a scarce resource, the ability to pay should not determine access to the medical resource, either because you have it or because you don't have money. Neither should influence position, kinship, friendship, religious belief, gender, etc. In other words, let yourself be carried away by the «law of the most influential».

Therefore, decisions regarding scarce medical resources should be made under priority schemes to select recipients, often in emergency cases. The strategies of maximum benefit for patients and social efficiency are highlighted; and those of equity of personal merit and fair opportunity (37). From equity and efficiency, as presented in this work, the considerations of maximum benefit would be fair, but not those of social efficiency. The objective is the highest productivity under criteria focused on medical considerations, for example, giving the resource to those who have the greatest possible success, or to those who achieve more days with quality of life measured by the Quality Adjusted Life Years (QALYS) or fewer days with disability through the indicator Disability Adjusted Life Years (DALYS); but not to choose from social considerations, for example, to provide the resource to the subject of «greater social value» or to exclude «unworthy candidates». However, combined considerations may be valid, such as privileging the resource for the youngest (38). The objective of the second strategies is equity, beyond the fact that maximum productivity is not achieved. Fair equality of opportunity is more akin to equity raised here than fairness of merit, which is controversial (32).

One way to avoid conflicts of interest in healthcare professionals and patients is to act by correct procedures and fair rules so that decision-making process is adequate, which requires awareness and ethical education, especially in our Latino culture that is not accustomed to procedural ethics. First, criteria and procedures are needed to determine a qualified pool of potential recipients, such as heart transplant eligible patients. Second, criteria and procedures are required for the final selection of patients, such as the patient who will receive a specific heart.

The criteria for screening potential health care recipients can be organized into three basic categories: circumstantial factors, progress in science, and the perspective of success. Within the circumstantial cases, one very frequent in contexts of high injustice, fostered by models of segmented health systems and that can re-

veal conflicts of interest, is to offer ample medical resources to those who have the capacity to pay. Another similar case is to offer organs for a transplant only to nationals, excluding immigrants.⁹ Both attempt against the fairness of justice. Those related to the progress of science refer to giving priority to patients whose treatment will give the most useful scientific information; they are for research and their use rests on moral and prudential judgments about the most efficient use of resources.

The probability of success is an important criterion to take into account, because a scarce medical resource should be distributed only to patients who have a reasonable opportunity of benefit. To ignore this factor is to commit an injustice, because its consequence is to waste resources; for example, offering a heart transplant to a patient who, because of his health condition, will take little advantage of it.

Judgments about the probability of success are value loaded, and the operational criteria for patient selection and their choice require careful institutional and public scrutiny to ensure that these values are defensible. For example, the debate about what counts as success in a transplant: graft survival time, patient survival time, quality of life, or rehabilitation (9).

The proposed standards for final patient selection have been more controversial than those for the initial selection. The debate has focused on medical usefulness, of which a word has already been said; impersonal mechanisms such as lotteries and waiting lists, which will be discussed below; and social usefulness.

The use of waiting lists is justified by considerations of equality and fair opportunity considerations, if social resources are scarce and not divisible in portions, and when selection determines life or death. Lists are an inevitable and rational planning resource. When the waiting time is reasonable, for example, a range of 14 days to 4 weeks, and when there is no urgency for treatment, waiting lists are a morally acceptable means, because they promote rational planning of benefits, as well as the proper use of available services and

facilities. However, given the growing demand for hospital care in Mexico, waiting lists are one of the reasons for the greatest dissatisfaction among the population. Waiting lists have become an indicator of the level of health care, but we have not yet reported in Mexico (20).

Within the waiting list method, three criteria have been used to establish treatment priority: attention in order of arrival, need for medical attention and possibility of medical success. All three criteria are morally valid. The first is that the time you have been waiting on the list is the main indicator of how long it takes to be treated, and never the favoritism or friendships or other types of influences that would go against the right to health care of the injured parties. The second is that a real emergency must take precedence over a lesser need, despite being an exception to the principle: equal cases should expect the same treatment opportunity. The third has already been discussed and is a decisive criterion for entering the waiting list (39).

One factor to consider is that some people do not enter the list or lottery on time, due to factors such as difficulty seeking help, inadequate or incompetent medical care, the delay of the health systems in sending the patient, or open discrimination. A health-care system is unfair if it does not prevent some from gaining an advantage over others in access, because they are better educated, better related or through money they get more frequent visits to doctors. In other words, in places of high social marginalization, equitable policies must be put in place that lead to the fulfillment of the right to health care for vulnerable patients (9).

In summary, waiting lists can be considered an adequate instrument for the fair distribution of resources in conditions of moderate scarcity. It is in these circumstances when it becomes possible to apply the moral principles that underlie the very existence and use of waiting lists. In conditions of excessive scarcity, the disparity between the demand for care and the supply of services increases in such a way that too many patients have to wait a long

time. It happens then that the moral principles that serve as the basis for the waiting list lose their discriminatory capacity. This is a factor to consider in places like Mexico.

Conclusion

The necessary distribution of limited health resources can be a source of conflicts of interest that must be regulated by a series of principles of justice. When dealing with elementary distribution issues such as the right to health or health care, or an adequate prioritization of health services, or the design of an adequate model of the health system, the principles converge in indicating elements of usefulness, equity and prioritization of the vulnerable, inalienable in any society or health institution that boasts of being fair. Equity and usefulness also regulate the conflicts of interest inherent in the distribution of resources when it is necessary to choose which patient has a certain means to save his life. It is the level in which the urgency of impartiality in the allocation is more visible and asks to learn to abide by a series of impartial procedures and rules. However, both distribution levels call for awareness and ethical education regarding the potential conflicts of interest that may arise. In countries with high social injustice such as Mexico, it is imperative to work for a fair distribution of resources that limits conflicts of interest that partially benefit some, neglecting equity, efficiency, and priority for the most vulnerable.

Bibliographic notes

¹ There are theories of justice that privilege the most vulnerable, such as prioritization. Priority is given to the least advantaged, whose condition falls below the level of sufficiency (16). Other theories, such as Rawls', uphold the principle of difference, whereby the unequal distribution of goods is only fair only if no other way of

articulating social institutions is capable of improving the expectations of the least favored group (13).

² For the purposes of this work, the resources considered will be those of public medicine, since the ethical conflict of interest in matters that affect the treasury is more important than in relation to private matters, having to do with property that is of the citizenship.

³ For the purposes of this work, the term «vulnerable» is used as equivalent to «disadvantaged» or «the poorest», without intending to enter into exact definitions.

⁴ According to the dictionary of the Royal Spanish Academy, to distribute is to divide something among several people, designating what corresponds to each, according to will, convenience, rule or right (8).

⁵ Rationing means subjecting something in case of scarcity to an ordered distribution (8).

⁶ Out-of-pocket expenses are those that must be made to obtain medical services that are not covered by public health or private insurance.

⁷ This is defined as «reverse care law» and prevails where health care is exposed to market forces (29).

⁸ One way to do this is through «accountability for reasonableness», which is a moral deliberation procedure that guarantees publicity, relevant reasons, review, and regulation (32).

⁹ Immigration is an issue that needs to be resolved at other levels, but not before two human beings who need the resource.

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