



Resource allocation in healthcare: Perceptions of the General Public

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Abstract

Sri Lanka provides healthcare free of charge to its citizens. Therefore, prioritizing resource allocation is especially important. The objective of this study was to determine public opinion on how scarce healthcare resources should be allocated. A questionnaire consisting of a scenario where the allocation of life-saving medical resources was required, was administered randomly in both Sinhala and English to 263 members of the general public, all of whom were over 18 years of age and residing in Sri Lanka (excluding health care workers, medical students and students of allied health-related subjects). The questionnaire was administered electronically and in paper format. The public was provided with 10 resource allocation criteria and requested to rank them in order of importance in relation to this scenario. Data were analyzed using Microsoft Excel and Jamovi software. Results revealed that fifty four percent of the respondents were of the opinion that doctors should make resource allocation decisions while 39% preferred hospital administrators to make decisions. The majority prioritized providing resources to those who were most ill, followed by those most likely to survive, with no significant differences in responses with respect to gender, educational level, and age. The study concluded that the majority of citizens were of the opinion that doctors should make resource allocation decisions as opposed to administrators, with life-saving resources being allocated to the individuals who were most severely ill, followed by those most likely to survive. The least preferred methods were random allocation and volunteer-based allocation. Therefore, the study summarizes popular opinion on the basis on which health care workers are expected to assign limited health care resources.

Keywords: demographic trends, equitable access, healthcare resource allocation, prioritization, public perceptions

Introduction

Although a developing country, Sri Lanka provides health care and education free of charge to its citizens. Vital statistical parameters indicate the success achieved by the Sri Lankan health sector in executing this task (Abeyesundere, 2001). The health care system in Sri Lanka is under the administration of the Ministry of Health, which functions under the central government. National health policies are implemented with the objectives of improving the health status of the public and reducing inequalities (Ministry of Health, 2016). However, due to many social and economic factors and limited resources it has become challenging to ensure that the public gets an equal chance of utilizing health services (Abeyesundere, 2001; Withanachchi et al., 2007)

Even though prioritization of resource allocation is a key challenge faced by any health system in any country, it is especially challenging in developing countries where there is a greater disparity between health care needs and available resources (Schwappach, 2002).

Prioritization is defined as making a choice based on a ranking process. Prioritizing takes place in all areas of the health care system where demand exceeds the available resources. Although decisions on priority setting and resource allocation are made at the National/ Provincial/ Regional/ Institutional and Individual levels (Arvidsson et al., 2010), it is a fact that resources should be fairly allocated guided by well-established, broadly applicable, ethical principles, acceptable to those who help sustain it; the tax payers (the general public). Population characteristics such as ethnicity, race or creed should play no role at all in this process, but allocation should meet public health needs (*Coronavirus Disease (COVID-19)*, n.d.)

Under certain circumstances such as pandemics, wars and natural disasters, medical resources can become severely scarce, causing numerous challenges with regard to prioritization and resource allocation (Emanuel et al., 2020). The COVID-19 pandemic, which spread across the world including to Sri Lanka, highlighted the need for making critical medical decisions with regard to prioritizing resource allocation (Emanuel et al., 2020). In a pandemic situation, the prioritizing criteria may differ from what is practiced under normal circumstances. For example, although ordinary health systems give priority to the sickest, in a pandemic it may be justified to give priority to saving the most lives, when scarce resources like ventilators, ICU beds and vaccines are allocated (Daniels, 2016).

In a democracy, involvement of citizens in the process of making key decisions is an important part of governance. Furthermore, ethically sensible recommendations do not always reflect the views of citizens. Therefore, researchers have developed various methods for soliciting public preferences to support policy makers in the process of decision making related to priority setting and resource allocation in health care (Núñez & Chi, 2021). Countries like Sweden, Norway, England, and Israel have developed procedures to engage the public in priority setting (Farmakas et al., 2017). However, in many other countries, the rationale behind allocation of health care resources is usually not explained to the public, and thus, little is understood and discussed (Broqvist & Garpenby, 2014). As a result, people tend to question whether the bases for allocation are well grounded. Therefore, there are discrepancies between public preferences and existing priority setting criteria. To enhance legitimacy and to ensure that these resource allocation decisions are acceptable, public opinion and preference need to be considered in the allocation process (Broqvist & Garpenby, 2014; Lim et al., 2012). Such information would be

very helpful and can serve to guide decision makers (Huseynov et al., 2020).

Many factors affect perceptions of the general public with regard to rationing and resource allocation in health care. They include the awareness that health care resources are limited and knowledge and acceptance of the principles guiding rationing. However, there is little transparency in the mechanisms used in priority setting, and the public is often unaware of the principles adopted for the purpose. Previous studies have revealed that the majority of the general public has a high level of awareness about resource limitations, but they do not accept rationing. In addition, it has been revealed that most people are only aware of two levels of rationing: macro (National) and micro (Clinical). This is understandable, as people gather information mainly from media about national/macro level rationing and via personal experience about clinical/micro level rationing. On the other hand, the public receives very little information about guidelines and criteria set at the meso (policy makers') level. Openness about the mechanisms of and principles for rationing would enable citizens to gain insights into the process. However, whether this will lead to unequivocal acceptance of results is, of course, debatable (Broqvist & Garpenby, 2014).

Preferences of the general public

Eliciting public preferences and values with regard to priority setting and resource allocation can provide policy makers with valuable information for decision making and would help to establish a more equitable healthcare system with better community participation (Núñez & Chi, 2021).

A study done in Cyprus to elicit public preferences in health care priority setting identified severity of the disease, age, type of disease, health

improvement after treatment, cost of treatment, and a healthy lifestyle as criteria that the public considers when setting priorities. Severity of the disease, age and type of disease were identified as the most important concerns. Participants had given priority to people with greater need for health care treatment based on the principle of necessity. According to this principle, health care services should be offered to the public according to the need/ urgency of the situation. Thus, those with severe disease should be prioritized. However, these choices do not favor sustainability of health care or value maximization (Farmakas et al., 2017)

A study conducted to assess the views of older people regarding priority setting and resource allocation revealed that a majority did not consider age as a priority. They preferred to let the doctor decide on priorities. Considering older people's views is important since people are living longer now, and therefore form a much larger share of the population than they did before. In addition, many of them have experiences of their own from using health care services and were found to have important views on priority setting. In contrast, younger people considered well-being, lifestyle and family situation as important factors during prioritization (Werntoft et al., 2007).

Allocation of limited medical resources during a pandemic is more challenging. The literature identified four main governing principles in decision making during such situations; treating patients equally, prioritizing the worst-off, maximizing social benefits and maximizing individual benefits. Treating people equally means giving equal chances to all patients at receiving scarce resources. Prioritizing the worst-off involves allocating scarce resources to patients in order of the seriousness of their illness or susceptibility to disease. Maximizing social benefits favors patients who provide direct benefits to communities, such as health

care workers. Maximizing individual benefits involves allocating scarce resources to save the greatest number of lives or to preserve the largest number of life years among treated patients, which generally favors younger patients (Buckwalter & Peterson, 2020a; Huseynov et al., 2020). Several other principles are also identified. They include the principle of social worth, the life cycle principle, and the principle of instrumental value, justice and equity (Farmakas et al., 2017; Núñez & Chi, 2021)

A study conducted in the United States to assess public attitudes towards priority setting and allocation of scarce medical resources during the COVID-19 pandemic revealed that a majority of participants agreed with the principle of favoring patients with the best chances of survival and also with the principle that prioritized patients who were worst-off. In addition, evidence supported the fact that allocation principles are affected by allocation stage. During initial allocation, when resources are allocated to newly diagnosed individuals, participants agreed with the principles of maximizing benefit and prioritizing the worst-off. However, in subsequent allocation stages, where resources are allocated to already hospitalized patients, participants supported the principle of treating all patients equally (Buckwalter & Peterson, 2020a).

Existing medical literature supports giving priority to younger patients when limited resources were allocated during COVID-19. A study done to assess public preferences for allocation of ventilators also found that the majority favored younger individuals. In this instance, the majority of respondents had preferred allocation of ventilators to those under the age of 40 years (Huseynov et al., 2020).

A study done in the United States with the objective of eliciting public preferences for priority setting when vaccinating against COVID-19 revealed that the majority had “high” willingness to allocate the vaccine to

front-line health care workers, followed by high-risk children and high-risk older adults (Gollust et al., 2020)

An online survey was conducted in Jordan to investigate potential differences in perceptions regarding the allocation of limited medical resources among different participant groups within the same society. The study aimed to compare these findings to those found in international literature. The survey included three hypothetical scenarios representing medical resource scarcity, including organ donation, hospital beds during flu epidemics, and novel therapeutics for lung cancer patients. Participants were asked to prioritize allocation criteria by ranking them from most important (score-1) to least important (score-9). At the end of the survey, respondents were given the option of leaving a free text-comment. The findings unequivocally revealed that the "sickest first" prioritization principle emerged as the most important consideration in all three scarcity scenarios (Yousef et al., 2021).

In many countries, health care workers had to apply strict rationing and ethical principles to utilize limited medical resources efficiently. The number of studies documenting the general public's views on this decision-making process is scant. It is accepted that the general public's preferences may vary geographically, racially, and socioeconomically, and understanding these attitudes can provide valuable insights into how healthcare systems can better serve the public (Buckwalter & Peterson, 2020b; Huseynov et al., 2020).

It is crucial to engage with the public to develop policies that meet the needs of all members of society. By considering public (tax payer) preferences, we not only obtain the views of the public to ensure that resource allocation strategies are acceptable to them but also ensure that their opinion is considered in the decision-making process.

Objective

To assess perceptions of the general public on prioritization and resource allocation in health care.

Methods

A questionnaire was constructed to assess the perceptions of the general public regarding priority setting and resource allocation in healthcare settings. The questionnaire was made available in Sinhala and English and consisted of a scenario where the allocation of life-saving medical resources such as ICU beds, HDU beds, and essential medicines had to be considered. The questionnaire was piloted on a convenience sample to determine its length and to resolve areas of ambiguity. We adopted a random sampling technique. The questionnaire was administered electronically and in paper formats to 263 members of the general public over 18 years of age and residing in Sri Lanka (excluding health care workers, medical students and students of allied health-related subjects). Participants were asked to rank their perceptions on the basis that should be adopted in allocating a limited resource, on a scale of 1-10 (most deserving- least deserving).

They were requested to consider the following bases;

1. The sickest individuals
2. Those who have been ill the longest
3. Those who are most likely to survive if given the resource
4. Those who have essential roles to play in keeping society operational (e.g.: forces)
5. Health care workers
6. Younger persons
7. Randomly e.g., via a lottery

8. Those who had contributed in the past to the common good
9. Volunteers
10. Those who can have a good quality of life due to the resource

Data analysis was performed using Microsoft Excel and Jamovi (version 2.3) software to determine the majority views on resource allocation in the healthcare setting. The mean and mode values were calculated for each criterion. The mean value was considered in determining the rank while the mode was considered when the same mean value was observed for two criteria.

The data were further analyzed based on age, educational levels, occupation, and marital status.

Results

The majority of the sample was female (56%) and between the ages of 26-55 years (71%). Eight percent was above the age of 56 years.

Fifty percent of those who responded have had tertiary or postgraduate education. Seventy five percent was in employment while 24% was not employed and 1% had retired. Sixty six percent was married.

Fifty-three percent had been admitted to a hospital at one time or another within five years prior to completing the questionnaire.

Fifty-four percent stated that doctors should make decisions about prioritization of healthcare resources for patients. However, 39% thought that hospital administrators should decide.

Table 1: Public perceptions on the allocation of limited life – saving medical resources.

Priority Order	Ranking criteria
1	The sickest individuals
2	Those who are most likely to survive if given the resource.
3	Younger persons
4	Those who have essential roles to play in keeping society operational (e.g.: forces)
5	Health care workers
6	Those who have been ill the longest.
7	Those who can have a good quality of life due to the resource.
8	Those who had contributed in the past to the common good.
9	Volunteers
10	Randomly e.g., via a lottery

Inference: The majority thought that limited life-saving resources should be given to the sickest individuals followed by those who are most likely to survive if given the resource. They did not consider random allocation or providing resources to volunteers as viable options.

Table 2: Public perceptions on the allocation of limited life – saving medical resources: Gender based analysis.

Ranking Options	Ranking	
	Male	Female
The sickest individuals	1	1
Those who have been ill the longest.	4	6
Those who are most likely to survive if given the resource.	2	2

Those who have essential roles to play in keeping society operational (e.g.: forces)	3	4
Health care workers	5	5
Younger persons	6	3
Randomly e.g., via a lottery	10	10
Those who had contributed in the past to the common good.	9	8
Volunteers	7	9
Those who can have a good quality of life due to the resource.	8	7

Inference: Both males and females prioritized the sickest individuals and those who are most likely to survive given the resource. Both genders considered that health care workers should get moderate priority while both males and females believed that the random method was the least appropriate, followed by allocating resources to those who had contributed in the past to the common good, to volunteers and to those who can have a good quality of life due to the resource.

Table 3: Public perceptions on the allocation of limited life – saving medical resources: based on educational level.

Ranking options	Ranking			
	Postgraduate	Tertiary	Secondary	Primary
The sickest individuals	1	1	1	1
Those who are most likely to survive if given the resource.	2	2	2	3
Younger persons	3	3	6	6
Those who have essential roles to play in keeping society operational (e.g.: forces)	4	4	5	5
Health care workers	5	5	4	4

Those who can have a good quality of life due to the resource.	6	6	9	8
Those who have been ill the longest.	7	7	3	2
Those who had contributed in the past to the common good.	8	9	7	9
Volunteers	9	8	8	7
Randomly e.g., via a lottery	10	10	10	10

Inference: The public, irrespective of their educational level, share a common point of view: the highest priority should be given to allocating resources to the sickest individuals with the least priority given to random allocation. Those with postgraduate and tertiary level education have nearly identical ranking systems for allocating limited life-saving resources. Those who have only primary or secondary education have given higher priority to those who have been ill the longest with low priority to those who can have a good quality of life due to the resource, as opposed to the group with a higher educational level.

Table 04: Public perceptions on the allocation of limited life – saving medical resources: based on marital status.

Ranking options	Ranking	
	Marr ied	Sin gle
The sickest individuals	1	1
Those who are most likely to survive if given the resource.	2	2
Those who have essential roles to play in keeping society operational (e.g.: forces)	3	6
Younger persons	4	4
Health care workers	5	5
Those who have been ill the longest.	6	3

Those who can have a good quality of life due to the resource.	7	7
Volunteers	8	9
Those who had contributed in the past to the common good.	9	8
Randomly e.g., via a lottery	10	10

Inference: Both married and single groups prioritized allocating life-saving resources to the sickest individuals, and to those likely to survive if given the resource.

Both groups did not consider random allocation, allocation to those who had contributed in the past to the common good, allocation to volunteers or to those who have the ability to have a good quality of life, as suitable criteria in distributing limited resources.

There was no consensus among the married and unmarried groups on the level of priority that should be given to those who have essential roles to play in keeping society operational (e.g.: forces) and those who have been ill the longest.

Public perceptions on the allocation of limited life – saving medical resources: based on recent hospital admission.

Those who had been admitted to a hospital during the last five years and those who had not, shared a similar perspective on the priority groups in allocating limited life-saving resources. They prioritize the sickest individuals, followed by those most likely to survive if resources are allocated. They assigned the least priority to those who had contributed in the past to the common good, to volunteers and to the random allocation method.

However, there was no agreement on prioritizing between those who have had recent hospital admissions and those who had not, when it came to decisions on allocating resources to those who have been ill the longest as well as to health care workers.

Table 05: Preference of the general public on the allocation of limited life – saving medical resources based on age.

Ranking options	Ranking				
	18 - 25	26 - 35	36 - 45	46 - 55	56 and above
The sickest individuals	1	1	1	1	1
Those who are most likely to survive if given the resource.	2	2	2	2	3
Those who have been ill the longest.	3	6	4	6	6
Health care workers	4	5	3	5	5
Younger persons	5	3	6	4	4
Those who have essential roles to play in keeping society operational (e.g.: forces)	6	4	5	3	2
Those who can have a good quality of life due to the resource.	7	7	7	7	7
Those who had contributed in the past to the common good.	8	8	9	9	9
Volunteers	9	9	8	8	8
Randomly e.g., via a lottery	10	10	10	10	10

Inference: Individuals in all age groups prioritized allocating limited life-saving medical resources to the sickest individuals and considered the random allocation method as the least suitable alternative.

Although persons younger than 55 years of age gave second priority to those who are more likely to survive if given the resource, the age group of 56 and above gave second priority to those with essential roles to play

in keeping society operational over those most likely to survive if given the resource (Edussuriya et al., n.d.).

Discussion

Although public perceptions about healthcare resource allocation are particularly important in developing countries with limited resources, such dilemmas are faced by medical practitioners world-wide and were particularly relevant during the COVID 19 pandemic. Public perceptions reflect societal values and expectations for fairness, equity, and access to healthcare, all of which are amplified during times of crisis. Understanding these perceptions is critical for policymakers to develop effective and socially acceptable resource allocation policies. By incorporating public perceptions into decision-making, policymakers can improve transparency, accountability, and, ultimately, trust in the healthcare system. Thus, this study not only sheds light on public sentiments, but it also provides invaluable insights for ethically sound, socially acceptable, and sustainable healthcare policymaking (Daniels, 2016).

The majority of respondents thought that limited life-saving resources should be given to the sickest individuals followed by those who are most likely to survive if given the resource (Yousef et al., 2021). Although there appears to be some contradiction in these priorities, it is seen that the general public recognized the need to address immediate medical needs, irrespective of prognosis. This may be due to the fact that they view this as the most morally justifiable course of action, as it aligns with the fundamental goal of healthcare – to alleviate suffering and preserve life (Emanuel & Persad, 2023). While there are minor variations based on gender, educational level, marital status, hospital experience, and age, the overarching consensus is to prioritize those in the most urgent need

of medical care. However, the fact that the respondents next prioritized those who are more likely to survive if given the resource contradicts with the first priority of providing the resource to the sickest individuals, and may provide evidence of the morality and spiritual leanings of the general public who thought that a very sick patient might deserve a resource even though they may not benefit fully from it. However, they did not consider random allocation or providing volunteers with scarce resources as suitable options.

When considering the priorities of the public based on age groups, individuals of all ages prioritized allocating limited life-saving medical resources to the sickest individuals and considered random allocation as the least suitable method. Although persons younger than 55 years of age gave second priority to those who are more likely to survive if given the resource, the age group of 56 and above gave second priority to those with essential roles to play in keeping society operational over those most likely to survive if given the resource.

Both males and females prioritized the sickest individuals and those who are most likely to survive if given the resource. Both genders considered that health care workers should get moderate priority and that the random method was the least appropriate. In the case of prioritizing younger persons, it appeared that more females prioritized younger persons as opposed to males (Davies, n.d.).

The public, irrespective of their educational level, shares common priorities: allocating resources to the sickest individuals with least priority given to random allocation. Those with postgraduate and tertiary level education have nearly identical ranking systems for allocating limited life-saving resources. However, those who have only primary or secondary education have given higher priority to those who have been ill the longest

and low priority to those who can have a good quality of life due to the resource, as opposed to the group with a higher educational level (Hadiyan et al., 2021).

Both married and single groups prioritized allocating life-saving resources to the sickest individuals, and to those likely to survive if allocated the resource. Both groups did not consider random allocation, allocation to those who have contributed in the past to the common good, to volunteers or to those with an ability to have a good quality of life, as suitable criteria for distributing limited resources. However, there was no consensus among the married and unmarried groups on the level of priority that should be given to those who play essential roles in keeping society operational (e.g.: forces), and to those who have been ill the longest.

Based on the last five years of hospital admission experiences, both groups, those with hospital experience and those without, shared a similar perspective on prioritizing limited life-saving resources. They first prioritized the sickest individuals, followed by those most likely to survive if resources are allocated, while they assigned the least priority to those who had contributed in the past to the common good, to volunteers and to random allocation methods (Khalife et al., 2023). However, there was no agreement on priorities between those who have had recent hospital admissions and others when it came to ranking those who have been ill the longest and health care workers.

Individuals in all age groups prioritized allocating limited life-saving medical resources to the sickest individuals and considered the random allocation method as the least suitable option. . Although persons younger than 55 years gave second priority to those who are more likely to survive if given the resource, the age group of 56 years and above gave second priority to those with essential roles to play in keeping society

operational over those most likely to survive if given the resource (Kolasa & Lewandowski, 2015).

Therefore, the study finds remarkable consistency in the prioritization of limited life-saving resources across demographic groups, such as gender, educational level, marital status, hospital experience, and age. Regardless of demographic factors, the majority of participants preferred allocating resources to the sickest people first, followed by those who were most likely to survive if given the opportunity. There may be a conflict between perceptions of the public and the perceptions of medical professionals, since a principle that is commonly used in these situations by medical professionals is utilitarianism which supports doing the greatest good to the greatest number of people. Implementation of this principle would give less priority to the sickest (who may not be able to benefit fully from the resource) and more priority to those who are actually able to benefit from the resource.

These results have significant effects on healthcare policy development and implementation. Understanding public perceptions toward healthcare resource allocation would help in developing policies that are not only effective, but also socially acceptable and ethical. Policymakers can use these findings to inform the development of policies that prioritize those in desperate need of medical care, maximizing the potential for saving lives and minimizing suffering. Furthermore, incorporating public perceptions into resource allocation decision-making processes is critical to increasing transparency and public trust in the healthcare system.

While the general public can provide useful insights, it is important to recognize that this perspective may not fully capture the complexities of resource allocation decision-making, especially from the perspective of

medical professionals and administrators. As a result, future research efforts could include conducting comparative studies to obtain the perspectives of healthcare practitioners and healthcare workers as well (Santos & Gonçalves, 2021). Policymakers can gain a better understanding of resource allocation dynamics by contrasting the perspectives of the general public with those with specialized knowledge and experience in healthcare delivery.

Conclusion

The majority of the public indicated that doctors should make resource allocation decisions, as opposed to administrators. They also indicated that life-saving resources should be allocated to the sickest individuals, followed by allocation to those most likely to survive if given the resource. The least preferred methods were random allocation and volunteer-based allocation.

Further studies need to be conducted regarding doctors' and other healthcare professionals' perceptions on resource allocation in order to determine whether a discrepancy exists between their perceptions and those of the general public.

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