Perspective

Ethics of Resource Allocation:

Dimensions for Healthcare Executives

By Peter A. Singer and Joseph Mapa

Financial pressures have forced your organization to undergo one more round of cost-cutting. Although, the organization has become cost-effective, expenses must be reduced further, and it has become clear that a number of programs have to be reduced and/or eliminated. What are the ethical dimensions of these choices?

What Is Resource Allocation?

Resource allocation involves the distribution of resources among competing programs or people. Although usually thought of only in the context of declining resources, resource allocation occurs when total resources are declining, stable or increasing. We hope that as the economic condition of Canada improves, the challenges will move from the former to the latter type. (1–3)

Resource allocation occurs simultaneously at several levels. First, governments decide how much to spend on health, and how to spend these resources. Second, governments may receive advice, such as on cardiac care from the Cardiac Care Network of Ontario, or they may delegate management of certain aspects of the system, such as parts of cancer care to Cancer Care Ontario. Third, in provinces with decentralized systems, regional health authorities make their allocation decisions. Fourth, senior healthcare executives decide how much to spend on various hospital programs and services. Fifth, program managers decide how to allocate available resources among patients. It is likely that each of these levels of decision making has particular nuances. For instance, in this article, we are focused on decision making by senior managers in hospitals, where mission will be a prominent element.

Not every ethical issue in a hospital is related to resource allocation. Conflict-of-interest policies in purchasing, the business and ethical challenges at the private/public interface, mergers and alliances, and human resource management represent issues other than resource allocation which are of great importance in hospitals.

The fact remains that economic exigencies will continue. The demand for healthcare exceeds affordable supply in every healthcare system in the world, and so resource-allocation decisions are inevitable. The goal becomes to make these decisions fairly. We therefore need to explore ways in which the allocation of resources can be made more consistent with ethical reasoning. It is in everyone's interest to practise ethical decision making whenever possible. Among other things, it shows respect for the interests of all those affected by the decision and a willingness to recognize that another's interests are as important as one's own.(4)

Why Is Resource Allocation an Ethical Issue and What Is Fairness?

Resource allocation is an ethical issue because it most fundamentally involves questions of justice. The goal of resource allocation then is to make fair decisions. So, what is a fair decision? Unfortunately, there is no consensus on what "fair" means, and this is where the dilemma begins. When one turns to the scholarly disciplines for help, the answer depends on whom you ask.

A philosopher would talk about theories of distributive justice. The problem is that these theories yield conflicting definitions. For instance, utilitarianism focuses on the maximization of benefit, while egalitarianism focuses on equality of opportunity and need.

A legal scholar would talk about procedures for decision making. As our colleague Bernard Dickens has noted, "The goal is not to make correct decisions but to make decisions correctly." In addition, issues of the *Canada Health Act*, human rights laws, and liability surface in the legal perspective on resource allocation.

An economist would focus on economic theories which have a utilitarian basis. The operationalized version of the theory is cost effectiveness analysis. The notion here is one of incremental

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return on incremental investment, where return is measured in health outcomes and investment in monetary costs.

A political scientist would focus on democratic theory and participation in decision making. She would ask about the involvement of the community, for instance, in hospital resource allocation decisions.

A management scholar would focus on the mission, program priorities, and quality of care.

A health scientist would focus on evidence-based medicine, which provides important information about the effectiveness and cost sides of cost-effectiveness equations.

What Criteria Should Managers Use for Resource-Allocation Decisions?

What is a healthcare executive to make of these ideas about fair resource-allocation decision making? There are five key interrelated concepts that resonate across the various disciplines – mission, quality, efficiency, need, and process.

1. Mission: According to Carver, an organization's mission statement "focuses on the difference the organization is to make in consumers' lives".(5) This is a useful starting point for resource-allocation decisions in a hospital. A hospital's mission is a Board policy that describes the fundamental ends of the organization. For instance, a pediatric hospital will not allocate resources for a geriatric rehabilitation unit. Of course, mission can change, and is open to interpretation. It is also unlikely that a hospital's budget can fulfill all demands, even if they are compatible with the hospital's mission.
2. Quality: Often singled out as an enticing criterion for allocating resources, the concept of quality is complex. Is quality defined in terms of clinical outcomes? What about competing judgments, disputed evidence, and numbers affected? Is it defined in terms of service and patient satisfaction, or more; societal vs. individual benefits; long- vs. short-term outcomes; quantity vs. quality of life; and/or clinician/staff satisfaction? Context is relevant. In a strong economic environment, quality benchmarks tend to be higher with available technological and personnel resources. In a tight environment, benchmarks may be reduced because that is the best that can be done with what is available. It is understood that while quality is an important variable, it is a vulnerable one.
3. Efficiency: In considering various program proposals, a hospital will seek to deploy its resources efficiently. Efficiency means, essentially, "value for money." What is the additional investment one needs to make for what additional health gain? Although this is the concept underlying cost-effectiveness analysis, such analyses are unfortunately not available for many of the decisions senior managers must make. Moreover, efficiency approaches contain two intrinsic problems – distribution and equality of access.
   First, efficiency approaches do not provide guidance regarding the distribution of resources across different individuals (or different programs serving different individuals). The same resources can achieve identical net health gains by producing a small gain for many people, or a large gain for a few people. An example from the Oregon experience is the prioritization of toothcapping over appendectomy.
   Second, efficiency approaches do not provide guidance with respect to overall program costs, and the resulting access issues. A program can be very cost effective, but at the same time so expensive that it cannot be offered to all who might benefit. A program can become very expensive either because the unit cost of the good or service is high, or because the problem to which it is applied is common. In an empirical study, Ubel showed that many decision-makers favor a less cost-effective program they could afford over a more cost- effective one which was so expensive, it could not be offered to all who might benefit.(6)
4. Need: The concept of need addresses these two issues. First, with respect to the distribution problem, needs-based approaches recognize the influence of the "rule of rescue" - a descriptive term for our tendency to try to "save" a specific endangered life when possible. Examples of the rule of rescue in the hospital setting are trying to save patients with cardiogenic shock - the chances of success are low but if we do nothing, death is certain. The issue here is a general one - the influence of death on resource allocation. Responding to the needs of dying patients can be inefficient, but is also an important part of how an organization represents itself to its community.
   Second, with respect to equality of access, needs-based approaches emphasize the total needs of the population served and associated program costs. How tradeoffs should be made between more expensive cost-effective and less expensive and cost-effective programs for the same population - balancing efficiency and need – is a crucial but unsettled question.
5. Process: Because resource-allocation decisions cannot be resolved on substantive grounds of mission, quality, efficiency, and need alone, organizations often appropriately resort to process solutions. Who is involved in

decision making? What is the input of the community and patients served? Process is particularly important because substantive principles - based on efficiency and need – may conflict. Process may provide a way to resolve these conflicts in a manner that will be generally regarded as fair.

How Should Managers Make Decisions When the Criteria Conflict?

Now we have come face to face with the challenges, complexities, and limitations of current approaches to resource allocation. How do these five elements come together in any resource-allocation decision? If a choice is most consistent with the hospital's mission, represents the most efficient expenditure of resources, enjoys positive clinical outcomes, is most responsive to those with the greatest need, and is the option chosen by an established process with appropriate representation including representation from the community affected, there is no problem. More commonly, however, these criteria - mission, quality, efficiency, need, and process - will point to different options for expenditure. In this type of situation, how should a fair resource-allocation decision be made? Theories from philosophy, law, economics, political science, management and health science do not provide an answer to this question, or, more accurately, they each provide a different answer. Even within a discipline, competing theories can be in conflict. For instance, within philosophy, utilitarian theories of distributive justice emphasize efficiency, but egalitarian theories focus on need.

This is where work needs to be done. We need to develop a "theory" of resource allocation that is interdisciplinary, empirically grounded and applicable. Interdisciplinary means that the theory spans the disciplines of philosophy, law, economics, political science, management, health sciences, and possibly others. Empirically grounded means the theory can help guide the actual decisions faced by healthcare executives.

Our message is this: there is no quick fix. The problem is not the absence of theory, but the presence of many conflicting theories that have never been explicitly reconciled, and do not always seek to provide practical guidance for actual decisions. At present, we can identify the main concepts related to hospital resource-allocation decisions - mission, quality, efficiency, need, and process. This is useful because it provides decision-makers with a conceptual framework and language to discuss situations, and to identify and describe the source of disagreements. However, current "theory" does not provide clear guidance on how to proceed when these criteria conflict in a particular case, as they almost always do. This advance in resource-allocation practice requires advance in resource-allocation theory. In the meantime, a systematic and explicit consideration of ethical issues in the decision-making process is clearly desirable. HQ

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Cover: ***Elevator*** 1989, acrylic on canvas, (104.1 X 76.2 cm) by Robert Pope (1956-1992). This powerful image of patients in a hospital elevator serves to illustrate that the demand for healthcare exceeds affordable supply in every healthcare system in the world. In this issue Peter Singer and Joseph Mapa explore the ethics of resource allocation that administrators face as a result.

Pope was diagnosed with Hodgkin's disease in 1982. He began to document his life as it unfolded. This created a portfolio of art that shows those who struggle with cancer; those who get better; those who die; the doctors; the hospitals; the methods of treatment; and the families of those who are afflicted. *Hospital Quarterly* will feature these paintings from time to time with the kind permission of the Robert Pope Foundation.