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Healthcare resource allocation decisions affecting uninsured services

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Abstract

Purpose—Using the example of community access programs (CAPs), the purpose of this paper is to describe resource allocation and policy decisions related to providing health services for the uninsured in the USA and the organizational values affecting these decisions.

Design/methodology/approach—The study used comparative case study methodology at two geographically diverse sites. Researchers collected data from program documents, meeting observations, and interviews with program stakeholders.

Findings—Five resource allocation or policy decisions relevant to providing healthcare services were described at each site across three categories: designing the health plan, reacting to funding changes, and revising policies. Organizational values of access to care and stewardship most frequently affected resource allocation and policy decisions, while economic and political pressures affect the relative prioritization of values.

Research limitations/implications—Small sample size, the potential for social desirability or recall bias, and the exclusion of provider, member or community perspectives beyond those represented among participating board members.

Practical implications—Program directors or researchers can use this study to assess the extent to which resource allocation and policy decisions align with organizational values and mission statements.

Social implications—The description of how healthcare decisions are actually made can be matched with literature that describes how healthcare resource decisions ought to be made, in order to provide a normative grounding for future decisions.

Originality/value—This study addresses a gap in literature regarding how CAPs actually make resource allocation decisions that affect access to healthcare services.

Keywords

Introduction

Finite resources are a reality for programs that provide access to healthcare, whether government-run, private insurance, or community-based safety net programs. Within the scope of those finite resources and informed by their hierarchy of values, policymakers must make a variety of allocation decisions, including who can be served and with what level of service. These resource allocation and policy decisions affect access to care for all people through costs for members and breadth of coverage. A variety of factors influence resource allocation and priority-setting decisions in healthcare, including economic factors and values – principles or judgments of what is important in life (Ahn *et al.*, 2012; Docherty *et al.*, 2012; Keren and Littlejohns, 2012; Kieslich, 2012; Littlejohns *et al.*, 2012; Maluka, 2011). In healthcare organizations, values are often codified in a mission statement, but the extent to which allocation decisions shaping healthcare services are consistent with those stated organizational values remains unclear.

This project aimed to describe resource allocation and policy decisions affecting access to care for the uninsured in the USA and to examine the relationship between organizational values and those decisions. Community access programs (CAPs) served as an interesting laboratory to examine these questions because CAPs shared characteristics of health provider organizations, public health organizations, and insurance companies. They provided an accessible forum to examine the understudied relationship between values and decisions. A focus on practical implementation of decision making and the factors affecting them will allow future work to avoid making unrealistic behavioral assumptions about how program managers make important decisions. Additionally, the description of how healthcare decisions are actually made can be matched with literature that describes how healthcare resource decisions ought to be made (Clark and Weale, 2012; Daniels and Sabin, 2002; Gibson *et al.*, 2004; Oddo, 2001; Slosar, 2004) in order to provide a normative grounding for future decisions.

Background

CAPs were a part of the safety net health system in nearly every state across the USA at the time data were collected for this project, which occurred between the passage and implementation of the Affordable Care Act (ACA) that aimed to reform the US healthcare system to dramatically reduce the number of uninsured individuals (Blewett *et al.*, 2008). In absence of federal legislation setting uniform parameters for access to care for low-income adults not eligible for Medicaid or Medicare insurance, local communities developed mechanisms to provide access to care for the uninsured. Some states mandated that local communities financially cover the cost of healthcare for the medically indigent, while in other states, counties developed their own methods to organize and finance access to a structured set of healthcare benefits at a low cost. As a result, CAPs were not designed as insurance products nor subject to state regulatory oversight (Blewett *et al.*, 2008; Minyard *et al.*, 2007). According to one survey of CAP typology, they typically included eligibility requirements, a defined set of benefits, an enrollment mechanism, a limited local provider network, and administration by a local organizing entity (Blewett *et al.*, 2008). The first of these types of programs was established in the early 1990s, but the majority developed with

support from a series of funding opportunities offered between 1998-2000 (Silow-Carroll *et al.*, 2004; Davis *et al.*, 2003; Nakashian, 2007). In 2013, approximately 55 CAPs were estimated to exist across the USA, serving between 80 and 25,000 individuals at any one time (Blewett *et al.*, 2008; Harrison, 2013). Prior evaluations of CAPs suggested participants preferred community tailoring, such that their culture, values, and needs were taken into account for program design (Silow-Carroll *et al.*, 2004). Though conforming CAPs to the needs of the community helped ensure the long-term support of stakeholders (Ryan, 2005, p. 17), it hindered replication in different communities (Minyard *et al.*, 2007) and generated skepticism that community initiatives could mitigate the uninsurance problem in the USA (Brown and Stevens, 2006). After the implementation of the ACA, CAPs found new ways to serve the formerly uninsured population, transitioning to insurance products or navigation programs.

Despite prior evaluations of CAP programs, to date no research has focused on resource allocation decisions or the factors and values influencing them. This study hypothesized that there would be a close relationship between organizational values and resource allocations that affect access to healthcare services at CAPs, since they were created to respond to community need and not subject to risk adjustment or regulation. Tracing the relationship and factors affecting it could provide a baseline against which future projects can compare the influence of values and contextual, procedural, political, and economic factors in other healthcare organizations, such as insurance benefit package and health system design. As previously described, nine organizational values common to the two participating CAPs were identified as relevant to organizational decision making: stewardship, care quality, access, service to others, community well-being, member independence, organizational excellence, decency, and fairness (Table I) (Harrison and Taylor, 2016). This manuscript describes resource allocation and policy decisions relevant to providing health services to low-income and uninsured individuals and describes the relationship between organizational values and decisions.

Methods

The qualitative research methodology contrasting two diverse cases has previously been reported; methods are summarized noting details relevant to the findings reported here (Harrison and Taylor, 2016). The study used a case study approach and multiple data types to triangulate and gain a detailed understanding of the context and process of CAP resource allocation decisions (Creswell, 2006, p. 73; Yin, 2008).

Study sample

Two CAPs were selected using a criterion sampling strategy based on information available online or from key contacts at each potentially eligible site (Creswell, 2006, pp. 126-127; Miles and Huberman, 1994, p. 28). Two of the eligible CAPs contacted and willing to participate were purposively selected based on the goal of organizational diversity, using the following criteria: organization and funding model, maturity as judged by founding date, and geographic location. Site 1 existed for less than five years in the Mid-Atlantic and was administered by a local health system; the $1.7 million budget was funded through a mix of

patient contributions, county taxes, and grants. Eligibility was limited to county residents up to the equivalent of having an annual income of $34,470 for a single person household and the resulting 750 individuals served at any one time received care from a single provider network. Site 2 existed for more than 20 years in the Southeast; a $132 million budget came from county tax revenue and was administered by a local health department. With eligibility set at the equivalent of making less than $11,490 annually with a single person household, between 14,000 and 17,000 individuals received care through one of four limited provider networks.

Recruitment

At each site, study participants were recruited from individuals professionally involved with designing, funding, and/or administering the CAP or its elements. Within this overall eligibility criteria, criterion and chain-referral sampling strategies were used to identify potential participants (Creswell, 2006, pp. 126-127). CAP managers and staff, CAP leaders or former leaders, or members of advisory boards were targeted as most proximally involved in making resource allocation or policy decisions. Every individual recommended was recruited for participation. Participants were recruited by a phone call or direct e-mail from the researcher or by an e-mail forwarded by a CAP key informant.

Human subjects

The IRB, University of California San Francisco reviewed the project and determined it not human subjects research because participants were responding on behalf of the organization rather than as individuals. Oral consent was obtained before each data collection event.

Data collection

Three methods were used: gathering archival materials, making direct observations, and conducting in-depth interviews. Archival materials included CAP website snapshots, internal policy reports, external policy documents, and prior evaluations (Marshall and Rossman, 2006, p. 119). Direct observations of staff and board meetings were conducted to witness interpersonal dynamics among staff, the process of decision making, and references to organizational values or other influencing factors (Marshall and Rossman, 2006, p. 133). Semi-structured in-depth interviews with key informants were conducted to explore resource allocation decisions and factors affecting them in greater detail (Creswell, 2006, pp. 132-134). Observations and interviews were recorded when permission was granted by participants; otherwise, hand-written notes were taken. Participants were invited to engage in at least two interviews. Semi-structured interview domains are described in Table II; interviews also used a listing exercise (Weller and Romney, 1988, pp. 9-14) in the first interview and a ranking exercise in the second interview to systematically elicit feedback on organizational values (Weller and Romney, 1988, pp. 9-14, 43-47).

The discussion of example resource allocation decisions in each initial interview elicited a list of criteria, options, and factors involved in the example decision(s), using qualitative probing and interview techniques borrowed from ethnography. Between interviews, these verbal narratives were used to create visual diagrams representing each example process and the factors affecting it. Diagrams were intended to capture the emic reasoning of decision

makers in a hierarchical model (Gladwin, 1989, p. 8). During the second interview, this diagram was revised in an iterative process of discussion with the informant, which also served as a member checking exercise to increase the credibility of the results (Creswell, 2006, p. 208). These diagrams were further refined during data analysis.

Data management

Observations and interviews were transcribed by a professional transcription service. Transcripts were reviewed for accuracy and completeness, and identifying information was removed or abbreviated to preserve confidentiality. Data citations in this manuscript use the following key: s1 for site 1, s2 for site 2, d for document, o for observation, or p for interview participant; a number following d, o, or p indicates the specific document, observation, or interview.

Data analysis

All data were converted to electronic format then uploaded into a computer-assisted qualitative data analysis software program: QSR's NVivo9 (QSR International Pty Ltd, 2010). A preliminary codebook of deductively generated primary and sub-codes was built based on the interview protocols and themes from data collection, including CAP structure, values, decisions, and factors affecting decisions. The primary coder (KH) applied the preliminary codes after reviewing all documents at least once and began inductively developing additional codes and revising preliminary codes. These additional inductive codes included the example resource allocation decisions discussed by members, named using emic or descriptive terms. A research assistant with qualitative methods training reviewed a subset of data (from each site, one interview, observation, and document, $n = 6$) to verify the clarity of the codebook and systematic application of the codes. Discrepancies were discussed and code definitions clarified; KH applied the final codebook to all data.

In all, 26 candidate example resource allocation and policy decisions were sorted into two categories: first, decisions that affected only internal CAP policies and rarely or minimally affected access to services for members or applicants ($n = 9$), and second, decisions that affected access to services for members or applicants ($n = 17$). Decisions in the former category were set aside as less relevant to the research question. Memos aggregating data from all sources were drafted for each decision in the latter category. Decision diagrams from different informants discussing the same decision were combined into a single decision diagram; any discrepancies were noted and resolutions sought. Five examples from each site with the richest data were chosen for further analysis based on those memos. To facilitate cross-site comparison, those ten example resource allocation and policy decisions were further categorized by the impetus for the policy design or revision: designing the plan, reacting to funding changes, or revising policies to reduce barriers or expand access. These three categories were derived by inductively looking for patterns and similarities across the richest of the example decisions available in the multi-modal data to identify common themes. Analytic memos were drafted for each of the ten example decisions along with within-case diagrams (Miles and Huberman, 1994, pp. 173, 91). An additional cross-site comparative memo was written comparing all themes – CAP structure, values, decisions, and factors affecting decisions – this deepened understandings of concepts discovered.

Validity

Member checking activities occurred through the review of decision diagrams in the second interview with participants; participants were asked to reflect on, alter, and add to draft diagrams as described above (Creswell, 2006, p. 208). Multiple methods (observations, interviews, and document review) and perspectives (staff, leaders, and board members) were used to capture the complexity of the case, setting, and processes with the goal of reducing the risk that the conclusions reflect only the systematic biases of single source and method(Maxwell, 2004, p. 93). These data were triangulated by combining all transcripts, notes, and documents into a single database and applying the codebook to all data; themes were then compared for similarities and differences by site, data source, and stakeholder perspective (Creswell, 2006, p. 208; Maxwell, 2004, p. 112). Participants were recruited and data collected at each site until no new relevant data emerged; this informational redundancy was sought to enhance rigor (Eakin and Mykhalovskiy, 2003). Alternative explanations for the study conclusions were considered (George and Bennett, 2005, p. 91) and discrepant as well as supporting evidence was sought (Maxwell, 2004, p. 112).

Results

Data were collected between September 1 and November 19, 2011. Site 1 data includes 15 interviews with nine individuals including five staff members, two board members, and two founders; six observations (three of board meetings, three of management meetings); and 81 documents selected from 868 provided. Site 2 data includes 26 interviews with 19 individuals including six staff members, six board members, and seven other stakeholders; four observations of one board member and three manager meetings; and 87 documents selected from 190 provided. All but two of the individuals contacted agreed to participate. The ten example resource allocation and policy decisions examined in detail fell into three types: decisions made during the process of designing the plans, those made in reaction to funding shortages, and those made when trying to reduce barriers or increase access to care for members. Of these, the two examples describing plan design are presented in detail; these are followed by a summary of the patterns in how factors affected the decisions across sites and examples.

Example resource allocation and policy decisions

Designing the plan (site 1)—The vision for the CAP came from newly elected and appointed county officials who believed universal access healthcare (s1 p8.1) would improve the health of the community (s1 p1.2). One county official organized a preliminary team of county health department staff to research the characteristics of the population in need, best practices in healthcare delivery, and existing access to care programs (s1 p7.1, p8.1). These individuals, who became the core CAP staff, wanted to use the wealth of resources in their county, "to address the needs of those without health insurance in a way that no one else in the nation has" (s1 d08). The concurrent national health reform debate increased political pressure on stakeholders to roll the CAP out quickly (s1 p6.1, p7.1, p8.1).

Based on their research, the stakeholders decided to utilize a medical home model and provide comprehensive and coordinated care in an effort to improve health outcomes (s1

p7.1). CAP stakeholders recruited the local hospital to provide pro-bono inpatient and diagnostic care; once the hospital agreed to participate, another local organization was recruited to serve as the medical home to provide primary and preventative care in return for a per-member per-month fee (s1 p1.1, p2.1, p7.1). Specialists were recruited to provide pro-bono specialty care as needed (s1 p1.1, p2.1, p7.1). Dental, vision, and mental health benefits were provided on a discounted or limited basis. CAP stakeholders created a mandatory health coaching program not only to motivate behavior change, improve health outcomes and address chronic conditions but also to foster personal responsibility for health in their members: "Because the whole idea of this [the CAP] was not only getting people access to care for when they need it but also help them change their lives to improve them so that we had long-lasting, sustainable healthcare system" (s1 p7.1). The design of the CAP was influenced by a reported desire to be viewed as innovative in order to attract additional funding and to be perceived as a model for national health reform (s1 p8.1).

To form an external oversight board, members were recruited from executive directors and representatives from provider partners and other community members – those who could provide advice on cost and revenue projections (s1 p2.2). Stakeholders assembled funding from county taxpayer dollars, private grants, and member premiums (s1 p1.1 and p2.1). Receipt of county dollars made the funding for the program a political target (s1 p6.1). The decision to require small monthly member premiums was based on a belief that it would encourage members to take personal responsibility for their own health; this was balanced against a desire to keep the plan affordable. Based on the projected budget, eligibility was restricted to people who were uninsured, under 300 percent FPL, county residents, and legal citizens or permanent residents of the U.S (s1 d02). Undocumented immigrants were excluded because of anticipated political objections related to the county funding (s1 p6.1, p7.1).

Designing the plan (site 2)—The home state of site 2 had a long-standing requirement that counties use tax dollars to provide free healthcare for indigent residents (s2 d04, p8.1, p18.1). The failure to fund indigent care in a sustainable manner culminated in an effort to directly control cost and also help the medically indigent in 1990 (s2 p9.1). Stakeholders did not want to "put any money into brick and masonry because there was a system out there; [they] just had to pull it together" (s2 p8.1). County staff, in conjunction with an advisory board, proposed a public-private partnership (s2 p9.1, p8.1): "a managed-care system designed to provide prevention and early intervention services with effective cost controls. Services would be delivered through a network of neighborhood-based primary care centers that would improve access to healthcare for indigents and reduce inappropriate emergency room use and hospital admissions" (s2 d04). The board of commissioners (a board of political appointees overseeing all county activities, including those of the CAP) approved the initial plan after requiring that family planning services be excluded from the CAP (s2 p8.1, p9.1). State legislation established a countywide half-cent sales tax to pay for the CAP; these funds were combined with *ad valorum* tax funds and stored in a trust fund (s2 d04, p8.1, p9.1, p10.1).

Stakeholders recruited four healthcare organizations to ensure members had equivalent access to care even in rural areas (s2 p9.1, p8.1, p18.1). Creating four networks also

prevented any one network from shouldering more of the burden or receiving more money (s2 p8.1, p9.1). Like site 1, these organizations acted as medical homes; unlike site 1, they were responsible for acting as networks, coordinating care for members and recruiting specialists as needed. Stakeholders established semi-capitated contracts with the networks to promote coordinated care (s2 p8.1) with bonuses for meeting certain indicators of quality care (s2 p9.1, p8.1).

Stakeholders created several different "plans" within the CAP, including an "all-inclusive plan" for county residents under 100 percent FPL and a "catastrophic plan" for people between 100 and 150 percent FPL with particularly high cost health needs (s2 p8.1). Eligibility was also restricted to county residents "because this was [the] County's money" (s2 p9.1) and excluded immigrants (s2 p1.1, p8.1, p9.1). Stakeholders decided not to cover high cost or generally elective services like transplants or cosmetic surgery because, "We're dealing with public dollars, remember […]. You have to be able to defend when the public stands up at the podium in a board meeting and says you're spending my money" (s2 p9.1). Family planning services were excluded at the time of plan formation because of opposition from county and state lawmakers (s2 p8.1, p9.1). Stakeholders also decided not to cover mental healthcare, because "we could have used all the money [from the] sales tax at that time just for mental health, so we said no" (s2 p8.1).

Factors affecting resource allocation and policy decisions

In the course of developing chronologic narratives for each of the example decisions and their accompanying diagrams, terminology was developed to analytically identify important types of influences. Contextual factors were defined as conditions external to the CAP, such as state conditions that affect CAP operations and decisions. Political factors included debate or conflict among individuals or parties having power or hoping to achieve such. Economic factors involved monetary support for the CAP or the management of available resources. Procedural factors related to CAP-related factors affecting how the decision came about (e.g. management structure, founding date, number of members, and types of stakeholders involved). Organizational values were defined as goals, motivations, and commitments of the organization or its stakeholders. Having identified these influential values and factors, their presence was delineated within each example decision. Table III summarizes all ten resource allocation and policy decisions used in the analysis and lists the trigger and result of the decision. It also shows how contextual, political, and economic factors affected the decisions and which organizational values were apparent in the outcome. The organizational values are listed in descending order of frequency of mention, starting with the most frequently mentioned value and ending with those values evoked at least once.

The ways in which procedural, contextual, political, and economic factors, as well as organizational values, affected resource allocation and policy decisions are reviewed below. The remainder of the results and the following discussion section highlights the procedural, contextual, political, and economic factors and the organizational values of access to care, care quality, community well-being, decency, fairness, service to others, member independence, organizational excellence, and stewardship in italics for clarity and emphasis.

Procedural factors—The process of making resource allocation decisions and the nature of the CAP's organization affected example resource allocation and policy decisions at both sites. Site 1 – which had been established and administered by a local healthcare provider system and financed by taxes, Medicaid funds, and grants – had closer control over services than site 2 – administered by a local health department and financed with county indigent care resources – which used a managed-care model of service provision. The founding date affected plan design decisions only in that site 2 designed their CAP with reference only to managed care organizations like Kaiser Permanente as a model; whereas site 1 was able to reference all fifty CAPs created in the previous 18 years and adapt what worked elsewhere to its own environment. At both sites, the success of the CAP can be attributed to strong, motivated leaders. The number of members served also may have impacted resource allocation and policy decisions in that site 1, with 750 members, might have managed their resources differently if they served the 15,000 members that site 2 served.

Most significantly, **procedural factors** such as the top-down management structure (s2) vs bottom-up (s1) impacted the ways in which problems were identified and solved. At site 1, problems were typically identified by CAP staff, or less commonly, providers or members. CAP staff then brainstormed potential solutions, discussed the solutions internally, then when the problem affected all members or overarching policy, brought the problem and suggested solution for discussion by the advisory board, which then approved draft and final policies and implementation processes. At site 2, though problems were identified in a variety of places including the advisory board (s2 pain management), study committee members (s2 self-sufficiency model), or the general manager of the CAP (s2 first funding shortage, pain management, expand access), the advisory board or study committee typically studied and chose the potential solutions, while the CAP staff provided data and drafted policies according to the advisory board's request. Although site 2 documents stressed the importance of the board of county commissioners as ultimate decision makers, interviews with advisory board members suggest their group thought through new policies and implementation processes, while the board of county commissioners simply approved its recommendations. Members were asked to participate on the CAP oversight boards at both sites, but at least at site 2, members did not routinely attend advisory board meetings. However, informants at both sites reported that member feedback at board meetings was greatly appreciated.

Contextual factors—Conditions external to the CAP, such as federal, state, or county conditions, affected CAP operations and decisions. Examples of **contextual factors** included a large immigrant community (s1 coaching), increased demand for preventive screenings (s1 colonoscopies), or high rates of narcotics use (s2 pain management). Some **contextual factors** directly impacted the monetary support for the CAP or the availability or management of available resources: the increase in property tax prices (funding shortage at site 2), great recession (s2 self-sufficiency model), or passage of the ACA (s1 funding threat, s1 queue). These shaped resource allocation and policy decisions in expected ways, by allowing for the creation of the CAPs (s1 and s2 plan design), constraining stakeholder choices (s2 first funding shortage, s1 funding threat), requiring stakeholders to accommodate

member needs (s1 colonoscopies, s1 coaching), or requiring stakeholders to change the shape of the CAP (s2 pain management, s2 self- sufficiency model).

Political factors—**Political factors** were defined as those related to debate or conflict among individuals or parties having or hoping to achieve power, either internal or external to the CAP. **Political factors** that affected decisions at both sites often stemmed from explicit political pressure from politicians. This explicit pressure was either positive, as when a political champion supported creation and funding of the CAP at site 1, or negative, when politicians refused to establish a CAP at site 2 if it provided family planning services. Other times the political pressure was implicit, or imposed by CAP stakeholders by themselves in anticipation of a political response, as happened in the case of the exclusion of undocumented residents from eligibility at both sites. Generally, stakeholders acted in accordance with both implicit and explicit pressure in the belief that doing so would allow the CAP to continue to exist or that stakeholders did not have sufficient political capital to oppose the pressure. In one case, stakeholders reacted in opposition to political pressure from the board of county commissioners (s2 expand access). Site 2 stakeholders reported that the political environment in their county became increasingly conservative over time, which influenced the types of changes that were made at the CAP in response to funding problems (s2 self-sufficiency model). Both sites felt they had to protect the CAP from being used as a political target at times; site 2 indicated they felt more direct political intervention in resource allocation and policy decisions because of the influence of the study committee, whose members were appointed by the board of county commissioners.

Economic factors—**Economic factors** were those related to the monetary support for the CAP or the availability or management of available resources. As expected, these affected many decisions at the CAPs. For example, the fact that site 1 relied on donated hospital and specialty care meant that in a funding crisis it could not cut services to reduce costs (s1 funding threatened). Site 2, however, paid networks for services, so in a funding crisis they were able to choose to cut both services and members to save money (s2 first funding shortage). At the time of its founding, site 2 had a dedicated and steady funding source of tax funds that should have ensured a stable income and limited funding shortfalls; instead, the funding stream was periodically co-opted (in highly political processes) for non-CAP related purposes that resulted in substantial funding instability over time. By comparison, site 1 had similar problems with funding shortages caused by its reliance upon on private grants for a significant portion of its budget, problematic during the recession (s1 funding threatened).

Organizational values—Finally, this study was particularly interested in discerning the impact of organizational values on resource allocation and policy decisions. At both sites, stakeholders referred back to mission statements and goals when thinking about what they were trying to accomplish. These mission statements were revised over time to reflect changing priorities. Arguments related to the values of *stewardship* and *access to care* were used to anchor or justify decisions, followed closely by *care quality*; both sites wanted to provide *access to care* by using limited resources thoughtfully. At both sites, *care quality* mediated the value of access to care – CAPs did not want to simply provide access to a bare

minimum of services to the most people possible, but instead prioritized the quality of the care (medical home model, comprehensive, preventive, coordinated) over numbers of members. At both sites, the value of *access to care* was complemented and reinforced by the value of *community well-being*. For example, both sites said that a motivation to create the plan was to improve the overall well-being of the community, both in terms of health and in terms of healthy people being more likely to work and fuel the economy. In addition, stakeholders routinely discussed the importance of *service to others*, for example, by providing a safety net for underserved low-income community members and advocating on their behalf. *Care quality* itself was constrained by the demands of *stewardship* – CAPs chose to limit access to some services (transplants, mental health) in order to maintain political and community support as well as to provide greater access to primary care. Both sites created policies to promote *member independence*, which required participants to give evidence that they were taking responsibility for their own well-being (s1 coaching, s2 self-sufficiency model) in order to continue to be eligible for the program. At site 1 this effort stemmed primarily from a desire to improve member health while at site two it originated in a need to increase CAP solvency by reducing member numbers. Other values such as decency, *fairness, and organizational excellence* were supplemental considerations in resource allocation decisions by guiding and supporting the application or balancing of other values, such as the tension between *stewardship* and *access* (s2 funding shortage, s2 pain management).

The relative prioritization of organizational values changed over time at both CAPs. When site 1 was founded, *stewardship, member independence, and care quality* were prioritized over *access* in some resource allocation and policy decisions (s1 plan design, funding threatened). Later, *access* was prioritized over everything short of *stewardship* in resource allocation and policy decisions (s1 coaching, colonoscopies, queue). At site 2, stakeholders involved during the plan design emphasized the importance of *stewardship* and *service to others* by providing access to care (s2 plan design, expanding access). As the CAP evolved, stakeholders prioritized *stewardship* (s2 first funding shortage, pain management) and *member independence* (s2 self-sufficiency model) over *access to care* or *care quality*.

Discussion

This study aimed to elucidate factors affecting resource allocation decisions shaping health services offered to the uninsured at two CAPs in the USA and examine the extent to which organizational values are apparent in the outcomes of those decisions. Within ten example decisions at across the two sites, multiple influencing factors were observed, including contextual, political, procedural, and economic factors, and organizational values. Stated values were apparent in the process or outcome of decisions, however, the manner in which CAP values affected decisions was not uniform. Contextual, economic, and political factors all changed the way sites weighed and balanced organizational values in a particular resource allocation and policy decision.

This study contributes to a relative dearth of literature empirically describing factors that affect resource allocation and policy decisions in meso-level allocation and prioritization decisions in programs that provide access to care for the uninsured. Meso-level decisions are

those made by healthcare facilities, in contrast to macro-level decisions made by governments and micro-level decisions made by healthcare practitioners. As healthcare costs rise, researchers and policymakers alike focus on effective and fair methods to control costs and divide up limited budgets for healthcare. Such resource allocation decisions are complex, requiring consideration of factors from multiple perspectives, including epidemiologic, clinical, economic, ethical, and political perspectives, including to what extent to maximize general population health, how to distribute health in the population, and how to address budgetary, practical, and political constraints (Baltussen and Niessen, 2006). Each perspective may lend itself to different methods of analysis that could result in different allocation or prioritization criteria or schemes. Much of the literature on resource allocation and priority setting in healthcare organizations focuses on criteria and tools for decision making from a single perspective, often that of economics or ethics (Baltussen and Niessen, 2006; Clark and Weale, 2012; Brock, 2005; Emanuel, 2000; Foglia *et al.*, 2008; Hasman, 2003; Litaker and Love, 2005; Littlejohns *et al.*, 2012; Smith, 2012; Tantivess *et al.*, 2012; Urquhart *et al.*, 2008).

Formal economic methods like cost-benefit analysis, cost-effectiveness analysis, or cost-utility analysis are intended to help decision makers determine whether a particular health service or treatment produces a favorable ratio of benefits to costs (Powers and Faden, 2006, p. 142). When decision makers need to select among or rank potential treatments or services, they can utilize one of these methods to evaluate the ratio of benefit to cost of each service, then use the outcome to select those with the most favorable ratio. However, the degree to which economic evidence is incorporated into resource allocation decisions depends on the transparency and clarity of both the economic evidence and the decision-making process itself (Niessen *et al.*, 2012). None of these formal economic methods were empirically observed within CAP decision- making processes, potentially because generating such analyses are more resource-intense than possible within the limited budget and staffing of CAPs. Instead, CAPs may implicitly and indirectly borrow economic analyses from health insurance plans, as exemplified by decisions to limit access to vision, dental, or mental health services. Ironically, this also an example of an area in which the organizational value of *member independence* could trigger a different decision if decision makers perceived that improved vision and dental hygiene similarly improved the employability of members.

This study is novel for explicitly examining the relationship between organizational ethics values and allocation decisions in community health organizations. Little work has been done to empirically describe how organizational ethics and values actually function within resource allocation decisions in community-based organizations. Instead, literature focusing on fair allocation of resources is dominated by normative statements of what ought to occur, rather than describing what does occur or making normative frameworks applicable to decision makers in community organizations. Examples of these normative criteria for decision making discussed in the literature include equity and fairness, efficacy, cost effectiveness, strength of evidence, safety, mission and mandate of healthcare system, need, and patient-reported outcomes; criteria of feasibility include stakeholder pressures and interests, organizational requirements and capacity (Guindo *et al.*, 2012). These normative criteria bear striking resemblance to the influencing factors empirically described by this study, including organizational values. For example, the feasibility criteria of organizational

requirements and capacity are related to both contextual and procedural factors that affect resource allocation and policy decisions in CAPs. The decision-making criteria of need, efficacy, cost effectiveness, strength of evidence and patient-reported outcomes are all related to the CAP organizational value of stewardship. As such, this study provides an empirical foundation that future initiatives can use to adapt normative criteria into an action guide that decision makers within community health organizations like CAPs can use to aid them in making ethical resource allocation decisions.

One of the strengths of this study is that it takes what is often implicit or tacit within healthcare organizations – values and decision-making processes – and makes it explicit. As a result, findings from this study immediately can be applied by leaders within community health organizations as well as inform future research.

Community health organizations may be able to use the findings of this study in discussions to make their own values and decision processes more explicit within their own organizations. Decision makers do not always have time to explore how the various factors influence their decisions, but this study provides a structure to do so efficiently, which could lead to more substantive discussions and potentially decisions that better align with values, or revision of stated values to reflect practice. Leaders of similar organizations might bring the list of organizational values and analysis of influential factors to their board of directors or executive team and have them review them and add any unique to their organization, then discuss how those values and influential factors are prioritized within their own organization or within specific decisions. For example, leaders that are forming new community health organizations may find inspiration in the narratives of how values shaped the development of participating CAPs. Further, leaders could develop a regular practice of identifying organizational values and checking how they are prioritized within particular decisions as priorities change over the lifecycle of the organization. At the beginning or in times of funding shortages, sustainability and *stewardship* might be the top priorities because without funding stability, nothing else is possible. However, in an established organization with reliable funding, *care quality* or might be prioritized as decision makers work to improve health outcomes in the population served while reducing costs. Values and influential factors could also be included in long-term strategic planning process, and used to generate identified goals and strategic priorities tied to measurable outcomes. In such a way decision makers could track and test the degree to which their values are apparent in their resource allocation decisions and priority setting over time.

Future empirical research can test hypotheses based on the findings reported here, beginning with the hypothesis that the organizational values and other influencing factors (contextual, procedural, economic, and political) described in the two participating CAPs also appear in other community-based health organizations in the USA and internationally. Further, researchers could examine and compare how different types of healthcare organizations with different sets of organizational values solve similar, perhaps standardized examples of, resource allocation dilemmas, including differences in prioritizations, processes, and outcomes, and compare the results to models of decision making.

Research is also needed to investigate how resource allocation policies are modified in the implementation process by mid-level managers, front-line clinicians, and members, and whether a similar or different set of values affect those decisions. For example, at one participating CAP, despite a policy to limit access to care to those with the equivalent of making less than $11,490 annually with a single person household, coverage was sometimes offered to people up to the equivalent of an annual income of $20,682 (s2 expand access). Similarly, in healthcare organizations that provide a set of services in exchange for a per diem or bundled payment, leaders may set policies that restrict available services or eligible parties while mid-level managers or clinicians may provide the care needed by an individual patient. Such research would address one of the limitations of this study – the inclusion of only decision maker perspectives, rather than implementer perspectives such as clinicians and members.

In addition, research is needed to examine the downstream effects of influencing factors on resource allocation decisions. Of particular interest would be population health research initiatives that examine causal relationships between the multiple types of decision-making factors identified in this study on health outcomes of members served by the community organizations (Friedman and Starfield, 2003; Kindig and Stoddart, 2003).

Finally, the empirical work of this project provides important data for the development of guidance for ethical decision making within CAPs and other community health organizations. The ultimate goal would be to produce a guide for decision making tailored to the existing CAP processes yet structured to help CAP policymakers make decisions that are more consonant with their own values as well as normative theory. Providing this guidance tool would help healthcare decision makers to identify ethical dilemmas in their decision making as well as promote explicit discussions of tradeoffs and tensions in allocation of resources. The action guide could then be tested for efficacy in CAPs and similar settings for its ability to aid decision makers in making resource allocation decisions consonant with their organizational values and in accordance with their internal decision-making processes.

Limitations

Given the exploratory nature of this research, two of roughly 50 CAPs nationwide were chosen in order to allow a deeper understanding of the CAP organizational values and decision-making processes; it also allows for the comparison of CAP experiences. The findings generated from these programs may have limited application to other CAPs, and conclusions should not be extrapolated to CAPs functioning during a similar period of time. However, future studies should explore the generalizability of this work in other healthcare organizations.

The possibility of social desirability bias, as well as recall bias, is a limitation for this study. However, the frank discussions of challenges and barriers experienced in running the CAPs suggests that the respondents felt comfortable expressing concerns about aspects of resource allocation decisions in CAPs. In addition, the use of observational data as well as written documents provided by the CAP allows for the comparison of data from different sources.

Participation was limited to CAP staff and CAP board members in order to facilitate an efficient examination of the study aims. CAP members and clinical providers that were not staff or board members were not specifically recruited for participation in the study based on a prediction that they did not participate in resource allocation decision making prior to the stage of implementing the decision. CAP oversight boards at both sites included at least one clinician and member each, so insofar as these individuals attended the observed board meetings, these perspectives are somewhat represented. Future research would benefit from focusing on the member and provider perspectives of what the organizational values and resource allocation decision processes are and ought to be.

Conclusion

Healthcare organizations and systems fundamentally shape the way patients experience healthcare. The resource allocation and policy decisions made by CAP leaders and stakeholders affected who could access care (e.g. the exclusion of undocumented immigrants at both sites, or the implementation of a "self-sufficiency" requirement at site 2), and the type of care CAP members could access (primary care but limited vision, dental, or mental health). Understanding the extent to which organizational values and other factors influence decisions that, in turn, affect services available to patients, is a step toward ensuring care is provided in accordance with mission and values. This work fills a gap in the empirical decision-making literature by providing language to identify the factors and values that affect both the process and criteria for making resource allocation and policy decisions. Healthcare organizations could adopt this language when discussing past or future allocation decisions to improve transparency for all stakeholders. The descriptions of resource allocation and policy decisions in the participating CAPs provide a basis for developing an action guide, or prototype framework, for ethical decision-making in the future. The description of how healthcare decisions are actually made can be matched with literature that describes how healthcare resource decisions ought to be made, in order to provide a normative grounding for future decisions.

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Table I

Organizational values and definitions

Organizational values	Definition
Stewardship	Thoughtfully invest resources to maintain program sustainability and financial viability
Care quality	Provide access to care with certain attributes, e.g. high-quality, preventive, primary, medical home based, comprehensive, coordinated, culturally appropriate
Access to care	Ensure or facilitate access to care for the maximal number of individuals and ensure affordability for members, which was sometimes cited as stemming from a belief in universal access (primarily at site 1)
Service to others	Take action to help specific groups of people (such as the low-income uninsured); to achieve specific outcomes (such as using the healthcare system effectively or become contributing members of the community); to provide a safety net; and to advocate on behalf of members and the underserved in the community
Community well-being	Improve well-being (including health) of individuals – including reductions in use of the emergency department – and improve the well-being of the community and provide a model for similar initiatives at the state or national level
Member independence	Promote personal responsibility (primarily at site 1) or self-sufficiency (exclusively at site 2) in members
Organizational excellence	Utilize good practices as an organization, such as acting in alignment with values, being transparent and accountable
Decency	Empower and treat members with respect, dignity, compassion
Fairness	Treat members, CAP staff members, and providers equitably

Table II

Domains and activities of in-depth interviews

Interview domains	First interview protocol	Researcher actions between first and second interviews	Second interview protocol
Introduction	Informant describes role within CAP, history of CAP, and other contextual questions		
Relevant to organizational values	In a listing exercise, the informant cites the goals, values, and commitments of various CAP stakeholders	Researcher prepares index cards of most frequently listed value terms and phrases in first interview	Informant rank orders value cards by the degree to which those factors affected the resource allocation and policy decisions, then discusses how and why
Relevant to resource allocation and policy decisions	Informant describes one or more recent resource allocation and policy decisions in which informant was involved	Researcher develops diagrams of example resource allocation and policy decisions and influencing factors based on aggregation of data from first interviews	Informant reviews a drawn diagram of one or more resource allocation and policy decisions and revise and adds details as necessary
Relevant to connection between the two			Informant places the value cards on the (revised) resource allocation and policy decision diagram(s) and discusses the relationship between value and resource allocation and policy decision(s)

Table III

Summary of all ten resource allocation and policy decisions and the values and factors affecting them

Example decision	Trigger	Contextual factor	Political factor	Economic factor	Organizational values	Result
S1 plan design	2007 election results and movement to provide access to care for uninsured residents (2007)	Beginning of great recession and discussion of national health reform 3rd wealthiest county	Politician champion Successfully sought county funding Exclusion of undocumented citizens and residents 300-500% FPL	Willingness of local providers to give discounted and pro-bono care Willingness of county and local organizations to provide funding	Stewardship Access Care quality Community well-being Service to others Member independence Decency Fairness Organizational excellence	CAP organized: one hospital, one FQHC medical home, ad hoc specialists Benefits "package": Primary care, hospital care, some specialties including cardiology Eligibility criteria established: residents 115-300% FPL, no undocumented immigrants
S2 plan design	County wanted method to control indigent healthcare costs (1980s)	State requirement that counties provide healthcare for indigent County had tried other methods	Board of county commissioners responsible for indigent healthcare funding Eligibility limited to incomes > 100% FPL, exclusion of immigrants Exclusion of family planning services, transplants, mental health, dental services	$12 million request from local hospital triggered CAP effort Obtained sustainable half-cent funding source Paid providers for first time	Stewardship Care quality Access Service to others Organizational excellence Community well-being Decency Fairness Member independence	CAP organization: 4 medical homes/networks Benefits 'package': primary care, hospital care, some specialties, no family planning Eligibility criteria: residents up to 100% FPL, no undocumented immigrants, small group of people 100-150% FPL
S1 funding threatened	One funder threatens not to provide promised funds (2010)	Passing of ACA - CAP now bridge to 2014	Insufficient political capital to maintain funds Implications of announcing membership cap	Funding threat ~500-600 members served with existing staff and budget	Stewardship Access Care quality Member independence Community well-being	Create member cap just above current membership, reduce staff slightly
S2 first funding shortage	With trust fund surplus; politicians halve sales tax and remove requirement to use property taxes in 1997 and cause severe funding shortfall in 2005	High housing prices in the county	Politicians slash CAP funding in 1997, prevented automatic increases in 2000 Some local politician strongly oppose CAP	Increase in members to 27,000 between 1997-2005 Trust fund has lower inputs after 1997 Trust fund gets too low to fund CAP in 2005	Stewardship Care quality Service to others Access Member independence Community well-being Organizational excellence	Cut dental, vision, pharmacy services, and people between 100-200% FPL, adds $1 co-pay for pharmaceuticals Membership drops to 13-15,000 (from high of 27,000)
S2 pain management	Routine utilization management	2008 attention to problem of	Discovery of system abuse by specialists	Some pain management	Stewardship Care quality	Chronic pain management and

Example decision	Trigger	Contextual factor	Political factor	Economic factor	Organizational values	Result
	review indicates high use and cost of pain management specialists	pain management and addiction State has highest rate of narcotics use Narcotics lucrative when sold on the street	Neighboring counties do not cover pain management for indigent Community engagement, incorporation of provider feedback	specialists charge for expensive procedures before prescribing high doses of narcotics Cost the CAP $3 million/ year	Organizational excellence Access Service to others Decency Community well-being Fairness Member independence	euphoric narcotics no longer covered; exceptions allowed for cancer and some blood diseases Added addiction services
S2 self-sufficiency model (SSM)	2009 recession drives membership up to 17,000 and decreases tax collection; Study Committee re-convened	2009 recession County social funding programs use SSM for their programs	Board of county commissioners believes in self-motivated improvement	Increase in demand, decrease in trust fund Stabilization of the trust fund triggers the suspension of the two-year limit	Member independence Stewardship Access Care quality Service to others Community well-being Organizational excellence Fairness Decency	Limit membership by implementing two year overall limit, requirement that all members must make progress toward self-sufficiency every 6 months Membership drops to 13,000 range Two year limit suspended in 2012
S1 coaching	Too few coaches to provide mandatory coaching service; cumbersome process to dis-enroll non-compliant people	Large immigrant population in community	Changes to board membership Coaching attacked by politicians as unwanted and too expensive	CAP in stable financial condition Resource-intense process to dis-enroll non-compliant people	Stewardship Member independence Care quality Access Fairness Community well-being Service to others Decency Organizational excellence	Coaching no longer mandatory; $10 premium reduction introduced to incentivize participation
S1 colonoscopies	Colonoscopy specialist asks to withdraw from CAP	Wait time for colonoscopy screenings becomes excessive	Implications of paying only one of several participating specialists	Specialist will only continue to participate if paid and number of screenings limited to 6 each month	Care quality Stewardship Access	Re-organize budget and apply for grant to pay colonoscopy providers Medicaid rates Create queue system
S1 queue	January 2012 sees significant increase in waiting list for CAP	ACA only 20 months away	Board decision not to ramp up CAP size	Insufficient budget to cover coaching for more members Cannot afford to pay to expand healthcare services	Access Stewardship Service to others Decency	First come, first serve; remove 'extra' expensive service (coaching), begin to move people off waiting list in bigger groups
S2 expand access	CAP stakeholders want to provide access to care for working poor with expensive illness	None detailed in data	Advisory board and CAP staff become willing to mitigate the impact of decisions to limit access to those under 100% FPL	High trust fund balance and interest rates enabled expanding access Financial stress causes later cancellation	Access Service to others Stewardship Care quality	Formal and informal decisions to provide coverage to working poor above the eligibility level (~180% FPL) through the expensive parts of their illness

Example decision	Trigger	Contextual factor	Political factor	Economic factor	Organizational values	Result
			Less oversight from board of county commissioners			