

# UCSF

## UC San Francisco Previously Published Works

### Title

Action Guide for Addressing Ethical Challenges of Resource Allocation Within Community-Based Healthcare Organizations.

### Permalink

<https://escholarship.org/uc/item/3jh9s90n>

### Journal

The Journal of Clinical Ethics, 29(2)

### ISSN

1046-7890

### Authors

Harrison, Krista L  
Taylor, Holly A  
Merritt, Maria W

### Publication Date

2018-06-01

### DOI

10.1086/jce2018292124

Peer reviewed



# HHS Public Access

Author manuscript

*J Clin Ethics*. Author manuscript; available in PMC 2018 August 01.

Published in final edited form as:

*J Clin Ethics*. 2018 ; 29(2): 124–138.

## Action Guide for Addressing Ethical Challenges of Resource Allocation within Community-Based Healthcare Organizations

Krista L. Harrison, PhD<sup>1</sup>, Holly A. Taylor, PhD<sup>2,3</sup>, and Maria W. Merritt, PhD<sup>4,3</sup>

<sup>1</sup>Assistant Professor, Division of Geriatrics, School of Medicine, University of California San Francisco

<sup>2</sup>Association Professor, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

<sup>3</sup>Core Faculty, Johns Hopkins Berman Institute of Bioethics, Baltimore, MD

<sup>4</sup>Associate Professor, Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

### Abstract

This article proposes an action guide for ethical resource allocation decision-making affecting access to healthcare services in community-based healthcare organizations. Using the filter of empirical data from a study of decision-making in two community-based healthcare organizations, we identify potentially relevant conceptual guidance from a review frameworks and action guides in the public health, health policy, and organizational ethics literature. We describe the development of this action guide through an iterative process of using data from a prior empirical study of values influencing resource allocation decision making in particular type of community-based healthcare organizations to evaluate, organize, and specify conceptual guidance available in fourteen relevant frameworks for ethical decision making. The result is an action guide that includes 4 domains relevant to the context of the decision, 8 domains relevant to the process of the decision, and 15 domains relevant to the criteria of the decision. We demonstrate the potential use of this action guide by walking through an illustrative resource allocation decision. The action guide provides community-based healthcare organizations with a conceptually grounded, empirically informed framework for ethical decision-making.

### Introduction

Community-based healthcare organizations provide access to health services tailored to the needs of their local community members. Many of these organizations form the backbone of a safety net system intended to serve the needs of uninsured and other vulnerable individuals whose needs are not otherwise met within the fragmented US healthcare system.<sup>1</sup> Examples include federally qualified health centers, local health departments, public clinics and hospitals, and non-profit healthcare organizations not affiliated with academic medical centers. These organizations at times wonder what is the right policy or resource allocation

---

**Corresponding author contact information:** Krista Lyn Harrison, PhD, UCSF Division of Geriatrics, 3333 California Street, Suite 380, UCSF Box 1265, San Francisco, CA 94143, Tel: 415.502.4684, krista.harrison@ucsf.edu.

decision given the potential impact on the population served. Such community-based organizations are not unique in this regard, but their administrators may have unusual latitude to make decisions based on community or organizational values rather than merely based on regulations or principles of profit maximization. A robust scholarly literature addresses general ethical questions about how to allocate healthcare resources in accordance with philosophical theories of justice.<sup>2</sup> It would be of little use, however, simply to hand this literature to an administrator of a community-based healthcare organization considering a specific policy change – for example, to facilitate equitable access to specialty care services. Accordingly, ethics frameworks have been developed to help decision makers translate theory into practice in specific problem spaces. Yet among the many frameworks on offer, none are comprehensively useful specifically for stakeholders within community-based healthcare organizations that provide access to health services. We sought to address this need. Our effort was informed by data that we collected within two of these organizations regarding policy decisions with morally important consequences, such as who will receive care and how much care they will receive, given limited resources.<sup>3</sup>

We reviewed existing ethics frameworks published for use in organization-level decision-making and identified potential normative support for decision-making elements empirically shown to be relevant to the type of community-based healthcare organizations we characterized in our prior empirical research.<sup>4</sup> We used the empirical data to evaluate, organize, and specify the conceptual guidance available in fourteen of the frameworks. The result is a conceptually grounded, empirically informed action guide that future empirical research can test and refine in a community-based healthcare organization practice setting. In this paper, we first describe the methods by which we created the action guide, then present the action guide, next provide a sustained example of how the action guide could be used, and finally discuss implications for future research and practice.

## Methods

We reviewed literature relevant to ethical healthcare resource allocation or policy decisions to identify guidance or frameworks relevant to meso-allocation decisions (organization-level) as distinct from macro-allocation (country-level or multi-system level) or micro-allocation (clinical rationing).<sup>5</sup> We consulted three main bodies of literature: public health ethics, health policy ethics, and organizational ethics. In recent years, frameworks have proliferated in the public health ethics literature to help “professionals identify and respond to moral dilemmas in their work”<sup>6</sup> designing and maintaining programs that promote population-level health. Because many public health ethics frameworks are oriented towards either macro-allocation or emergency circumstances, however, we also reviewed the health policy ethics and organizational ethics literatures for similar action-oriented guides relevant to dilemmas experienced by community health organizations. Health policy ethics examines the values underlying public program and policy decision-making.<sup>7</sup> Organizational ethics helps organizations to sustain ethical cultures and make decisions consistent with their fundamental aims, examining issues such as integrity, responsibility, and choice.<sup>8</sup> From the literature we reviewed, we selected 14 ethics frameworks for further analysis: 5 from public health ethics<sup>9</sup>, 5 from health policy ethics<sup>10</sup>, and 4 from organizational ethics<sup>11</sup> (Figure 1).

An ethics framework should be grounded in theory but approachable enough for a professional decision maker to use it without specialized ethical training. One way to satisfy both criteria, relative to a specific type of decision-making context, is to work back and forth between the normative literature about how decisions *ought* to be made and empirical data on how decisions actually *are* made in that type of context. We used our empirical findings about decision making in a particular type of community-based healthcare organizations<sup>12</sup> as a lens through which to filter, aggregate, and specify the normative ethical literature.

Normative frameworks sometimes distinguish between substantive normative criteria for decision-making and an ethical process of decision-making. For example, Marckmann et al.<sup>13</sup> include both elements in their framework, whereas Daniels' Accountability for Reasonableness focuses exclusively on process.<sup>14</sup> In addition to those two categories of decision-making elements – criteria and process – we empirically observed that organizational decisions are impacted by the social context of the decision, much in the same way that individuals' behaviors are influenced by social context.<sup>15</sup> Hence our three analytic categories were context, process, and criteria.

To develop the action guide, we first re-analyzed our empirical findings to create a table of the example decisions and the factors and values affecting them, categorized by context, process, and criteria for decisions (Figure 2). Second, we similarly categorized the normative considerations within the 14 selected ethics frameworks as relevant to the context, process or criteria of decision-making in our empirical data. Third, we compared the considerations within the normative frameworks to each element of the empirical findings with the goal of identifying a normative foundation for each empirical element (Table 1). Where we found multiple normative considerations that aligned with an empirical element, we chose the normative consideration that required least specification to be relevant to the empirical element; if all normative consideration options were similar, we chose the version in the most recent publication. When a normative consideration seemed related to a concept that appeared in the empirical data but had not been previously listed as an empirical element, we re-examined the empirical data to see if that concept was prevalent enough to warrant drawing it out as a separate empirical element.

We excluded from further analysis any normative considerations that were not relevant to any empirically-observed elements of the context, process, or criteria for decisions. Fourth, we reviewed the chosen normative foundations in comparison to the empirical element, and specified them for use in community-based healthcare organizations. No single conceptual framework adequately accounted for all the elements empirically documented as involved in community-based healthcare organization resource allocation and policy decision-making processes. Only by combining normative considerations from all three sections of the ethics literature (public health ethics, health policy ethics, and organizational ethics) were the empirical elements sufficiently supported. In addition, not every empirically observed element had a normative foundation (for example, some elements were purely political). Consequently, the final version of the action guide uses only 10 of the 14 frameworks; the 27 domains include both normative and practical decision-making considerations.

To refine the action guide for ease of use by decision makers in community-based healthcare organizations, we formatted each element as a question that decision makers could ask of themselves or their leadership teams. We tested the usability of the action guide by developing an example decision using the data from one of the 10 example resource allocations that we have described elsewhere in reporting the results of our prior empirical research.<sup>16</sup> We also used the illustrative example decision to check for redundancies in the action guide domains and to organize the domains of each category according to the order in which they were relevant to the example decision. We present below the resulting illustrative example decision.

## Results

### The Action Guide

The result of our analysis is the action guide that we offer here (Table 2). The action guide asks decision makers to consider the context of the decision, the process by they wish to make the decision, and what criteria they will use to choose between options or evaluate the quality of options. Although we will present the action guide as if used prospectively to make a decision, it could also be used retrospectively to evaluate the ethical quality of a prior decision. We anticipate decision-makers would use the guide iteratively both to analyze the problem with which they are struggling and to evaluate proposed solutions.

### The Action Guide in Action

The following example illustrates how administrators in a community-based healthcare organization could use our action guide to review and revise a policy concerning the healthcare services available to members. We have developed this example as a hypothetical scenario, informed by historical data to make it as realistic as possible, and presented from the standpoint of administrators at a community-based healthcare organization. The example combines data on what actually occurred with our analysis of what ought to occur in similar circumstances. To follow a realistic sequence of decision making, we demonstrate the iterative use of the action guide through multiple stages of the decision, from analyzing the problem in light of existing policy, to developing the revised policy, to implementing and monitoring the outcomes. As a result, we present five stages of using the action guide – one for *context*, two for *process*, and two for *criteria* – with the categories of *process* and *criteria* subdivided to reflect considerations relevant to revising the policy and to implementing the policy. Domains of the action guide are underlined in the text of the example and referred to by domain number.

**Identification of a potential policy problem.**—In the course of conducting a routine review of how members have utilized available healthcare, administrators notice that 2% of their organization's annual budget of roughly \$3 million has been spent on pain management specialty services, including expensive procedures (*e.g.*, local anesthesia followed by an injection into the spine to administer anesthetic and anti-inflammatory medication as guided by live X-ray imaging). No restrictions on accessing these services are in place; all claims submitted by providers are paid by the community-based healthcare organization are paid in full. Administrators seek to examine why these costs were high, to create a plan to manage

the costs of pain management services, and potentially to revise the policy on access to pain management services to address inappropriate utilization.

**Consideration of the context of the current policy.**—The administrators begin by re-establishing the fundamental commitments, goals, and values of the organization (1). Based on the organization’s mission statement, key considerations include how the policy affects access to care (especially for vulnerable populations), the quality of the care available, and the efficiency with which resources are used. These administrators are not alone in their concern about how pain management specialty services are being accessed. After a number of years focusing on undertreatment of pain, since 2008 attention at the federal, state, and local level (2) has turned to overtreatment of pain and associated rates of narcotics use and abuse, blamed in part on the evolution of treatment practices in chronic pain management. At the time this policy is being reviewed, the organization’s home state is identified as having the highest number of prescriptions written for opioids and rapid increases in the number of opioid-related deaths, a problem blamed on the number of specialty pain clinics and lack of associated regulation. When considering economic factors (3) relevant to a potential policy revision, the administrators are concerned that the relatively high proportion of funds being used for specialty pain management services has been driven by the resale value of narcotics on the street. To assess the political feasibility and community acceptability (4) of revising the organization’s policy, the administrators ask their neighboring counties whether and how they provide access to pain management for medically indigent residents. They learn that these counties have completely stopped coverage.

**Consideration of the process of reviewing and preparing to revise the policy.** —The administrators want to facilitate the participation and contribution of representatives from various affected stakeholder groups (5) in the process of reviewing and revising the organization’s policy. They start by consulting with the medical committee of their oversight board – which includes the medical directors affiliated with their four member networks – and asked them to help determine whether the current utilization of pain management services is reasonable and appropriate or whether changes are needed. In addition, they speak with all the primary care providers in the four networks, representatives from the local medical community, the local public safety committee (*i.e.*, police department leadership and judges), the Sheriff’s office, and their own two oversight boards, regarding whether these stakeholder groups would want the management of pain to change in this county, and what their suggestions might be for doing so. The oversight boards themselves have diverse stakeholder representation, from medical professionals to community business owners to members receiving healthcare through the organization. By engaging stakeholder groups, the administrators learn that primary care providers do not feel comfortable prescribing narcotics for members asking for pain medication, and that all stakeholders are interested in changing the existing system of pain management. The administrators also begin to engage other community partners with whom they anticipate needing to collaborate in the implementation of any policy changes or revisions -- for example, detox unit and substance abuse inpatient programs.

The next step in examining the existing policy and preparing for potential changes is to review the best quality data available to inform the decision (6). The administrators examine claims data on current and past member utilization, qualitative data from key informants with network, pharmacy, or medical expertise, and systematic reviews from the peer-reviewed literature on recommended practices in pain management. Based on analysis of the claims data, they see groupings of separate claims for a series of expensive procedures that do not align with the best practices reported in the peer-reviewed literature. They also see claims for ongoing high-dose narcotics prescriptions, sometimes with higher doses after procedures intended to reduce pain. Pharmacy and medical experts opine that the pattern of claims data suggests that pain management specialists were trying to bill the organization for a number of high-cost services, since the procedures were not reducing narcotics utilization. In-network physicians provide anecdotes of patients reporting that when they asked the pain management specialists for narcotics prescriptions, they were required to get these expensive procedures first, perceiving that if they refused the procedure no prescription would be provided. Based on these data – which are of the highest quality practically available on a short timeline – the administrators decide to amend the current policy, which allows unfettered access to pain management services. They create a supporting document that enables them easily to compare the costs of different services so that tradeoffs can be explicitly examined (7). The remainder of the process domains (8–12) in the action guide are left to evaluate at a later stage, as part implementing the revised policy.

**Consideration of the criteria for revising the policy.**—The first criterion to consider is how revising the policy will impact access to care (13). As noted earlier, neighboring counties have simply decided to no longer provide coverage for pain management. Because the administrators believe there will always be patients who need access to those services, as for cancer pain, they want to preserve access wherever possible. In an effort to be ethical stewards of their resources, they also consider potential impacts of setting new limits on access to care (14); their goal is to reduce expenditures but not to the point of creating undue burden on those in need of pain management. Next, they look at the evidence on the clinical effectiveness of treatments in achieving their desired goals (15) of relieving members' pain and reducing the frequency with which long-term narcotics are prescribed. In addition to consulting the peer-reviewed literature, they speak with experts in best-practice pain management, and seek information on how other healthcare organizations and insurers structure access to these services.

The administrators use their analysis of factors contributing to the problem and the evidence on clinical effectiveness of treatment to define what type and quality of care will be available to ensure appropriate access to medical services (16). They want to encourage members to use their primary care providers as the main source of pain management services, but also still allow access to pain management specialists. For this reason, they decide to require prior authorization of referrals to specialists before commencing treatment, and to limit access to an initial evaluation and no more than two follow-up visits per problem-based referral. Based on their understanding of clinical effectiveness compared to costs, they decide to cover procedures to diagnose or treat pain only in the cases of acute injury, dental pain, and pre- and post-surgical events, and reimburse for a limited number of steroid



injections restricted to specific diagnoses. Finally, they decide to provide only those members who have diagnoses of cancer, or blood disorders such as sickle cell, with access to chronic pain management, defined as treatment for longer than 60 days, or 90 days post-surgery. They will remove euphoric narcotics from their pharmacy formulary to address concerns about members requesting narcotics because of addiction, or for purposes of drug diversion, rather than for pain treatment proper. They believe that this proposed policy revision will allow them to continue to serve the diverse needs and preferences of their members by being compassionate, flexible, and responsive to individual values (17).

As they think ahead to implementation, the administrators consider how this proposed policy revision will impact those who are most vulnerable in the sense of being least healthy (18), defined as members who are receiving high doses of pain management drugs and who may be addicted. Administrators designate a 60-day transition period for the implementation of the policy. They also develop mechanisms to wean members off pain medication, including a collaboration with community partners to provide access to a detox unit or substance abuse inpatient program, in addition to the organization's existing coverage of substance abuse and some mental health treatment. This proposed policy revision may cause burdens, or harms, to the subpopulation of members (19) who are currently receiving pain medication. If they do not fall into one of the protected categories, some members may be physically and mentally reliant on the treatments and may experience substantial emotional and physical distress as a result of the proposed revised policy. Other members may be engaged in the illicit diversion of pain medication; for them, the proposed revised policy might cause an economic setback from the loss of income. Nonetheless, the administrators believe that the proposed policy decision treats similar members alike and fairly treats subpopulations of members without consideration of age or family situation (20). They believe it prioritizes access to symptom-mitigating care for those patients who are taking responsibility for their own health and aiming to become independent (21). They further believe that the decision will help empower members to achieve their desired ends (22) of receiving adequate pain management while reducing opportunities for addiction, or helping them to overcome addiction. While the policy does not restrict autonomous choices made by members (22) about pain management treatment, the proposed revised policy provides financial coverage only for a subset of those potential choices (e.g. for short-term pain management specialty treatment except for members with particular diagnoses). Under the proposed revised policy, the organization will continue to provide all covered services to members for free, thus matching costs to members with their ability to pay (23). As a result of this proposed policy revision, the administrators anticipate that spending on pain management services will drop significantly, thus improving the organization's financial viability and long-term sustainability (24) and allowing funds to be re-allocated as needed. The remainder of the criteria domains (25–27) are left to evaluate as part of the criteria for implementing the revised policy.

**Consideration of the process of implementing the revised policy.**—Having drafted the revised policy, the administrators enable the participation and contribution of stakeholders with varied interests (5). For example, they present the data they have used to analyze the problem, their assumptions, and their proposed revised policy at public meetings



of their oversight boards in order to seek reactions and recommendations, and in order to make the inputs and process publicly transparent (8). Administrators also seek feedback from other stakeholders consulted earlier in the process. They make the final policy publicly available (8) and actively educate members and providers about the changes. In the process of revising and implementing the policy, administrators have sought to maintain trust with members, and to treat them with compassion, respect, decency, and dignity (9), by continuing to provide access to services for people in need, including those with blood disorders like sickle cell. They have strengthened their relationship with addiction treatment service providers to whom they can refer members who have, as an unintended consequence of the previously open coverage policy, developed addiction problems.

The administrators believe that the resulting decision reflects the organization's fundamental values and goals, and their commitment (10) to providing access to care for the medically indigent in their community, while supporting responsible stewardship of the organization's resources. Administrators will hold themselves accountable for the process and outcome of the decision (11) to their oversight boards and to the general public whose taxes financially support the program. Administrators will closely monitor key outcomes of the revised policy: specifically, overall costs of pain management for members, patient utilization of the organization's services (e.g. whether patients remain members or switch to other forms of insurance like Medicaid), and the continuing provision of services to members by pain management specialists. They will implement transparent procedures for members and providers to appeal pain management coverage decisions under the revised policy. After 6 months, they will re-convene to assess whether, based on outcomes, appeals, or other conditions, the policy should be revised (12).

**Considering the criteria for implementing the revised policy.**—Analyzing whether the benefits and burdens of the policy revision are fairly balanced (25) requires examination of the effect on both members and providers. The burdens will accrue only to those members experiencing pain management needs, while benefits will accrue to all members if the organization can reallocate resources to improve member services. Members experiencing pain management needs will bear an increased burden in the form of needing to seek referrals from primary care providers before being able to access pain specialists. As a result of the policy change, members who are illicitly diverting and selling narcotics for personal gain will no longer enjoy a type of economic benefit that would be inappropriate for the organization to subsidize. Particular benefit will accrue to those patients who are undergoing the serious health crisis of addiction (unwittingly facilitated or precipitated by the old policy) and who are willing to receive help from the newly supplemented services. Considering the impact on providers, the burdens of the decision will primarily fall on pain management specialists – who will lose some income as a result of the policy change – and on primary care providers who will now be required to take on greater responsibility for managing patient pain and monitoring referrals. Burdens will commensurately fall on pain management specialists to the extent that they were engaging in problematic practices. The health of the community will benefit (26) if this policy revision reduces the prevalence of addiction. The net benefit to community health gain would be reduced, however, if this policy change exacerbates violence committed by criminal organizations. In order to

mitigate this unintended but foreseeable adverse consequence, administrators have explicitly alerted law enforcement to the possible impact on the local market in illicit narcotics. On the whole, if the new policy is successful, this decision will promote social policy reform and wellness (27) by demonstrating the feasibility of providing responsible access to pain management services for the medically indigent, by contrast with the more draconian option of not covering these important services at all.

In summary, this action guide provides decision makers with a conceptually grounded guide to making or evaluating policy change within their community-based healthcare organizations. The action guide is responsive not only to those items classically included in ethical frameworks for decision-making, but also to the values and mission of organizations themselves, and to practical considerations such as the political landscape within which the decision is made.

## Discussion

In developing this action guide, we have taken a novel approach both to its construction and its elaboration. The most common guides or frameworks for ethical decision making are conceptual and provide guidance either at the level of macro-allocation, useful for leaders of countries or states (*e.g.*, to guide health reform) or at the level of micro-allocation to guide clinical rationing at the bedside, often during emergency circumstances.<sup>17</sup> For organizations operating at the level of meso-allocation, like community healthcare organizations, professional societies are a more common source of ethics guidelines.<sup>18</sup> Conceptually grounded action guides useful to administrators are rarely generated in the academic literature, and even more rarely are they informed by empirical data about the process of decision-making. In developing our conceptually grounded, empirically informed action guide, we aimed to adapt the strong conceptual foundations available in the academic literature to the needs and context of community-based healthcare organizations, and thereby to create a product that could be used “off the shelf” with no additional training. Our illustrative example shows what it might look like to use the action guide, and simultaneously models the process by which future empirical research can refine it.

Additional empirical research is warranted to continue to improve the action guide and to study how community-based healthcare organizations can effectively deploy it. One line of research should test whether the elements of decision making empirically identified in the subcategory of community-based healthcare organizations that we studied appear in other types of community-based healthcare organizations, and whether there are additional elements that need to be accounted for. This line of work could also examine how different sets of organizational values (part of the context of the decision) impact the tradeoffs made by organizations between criteria of the decision; such work would form the basis of a hierarchy for addressing decision-making tradeoffs. A second line of research should test the pragmatic utility of our action guide for health policy decisions at the level of meso-allocation. Using survey development techniques, researchers could cognitively test the language of the action guide for clarity and utility. Research should also be conducted to obtain feedback from community-based healthcare organization decision makers to improve the usefulness of the action guide – for example, to find out whether there is an order of the

subdomains that would be particularly useful. Research could also be conducted to assess the extent to which the use of an action guide promotes explicit consideration of organizational values and ethical tensions and dilemmas, or whether the results of the deliberations produce resource allocation and policy decisions that are better aligned with ethical norms.

A community-based healthcare organization that incorporates routine use of the fully developed action guide into decision making could, at minimum, expect to see improvements in the degree to which decisions are made systematically, transparently, and in accordance with the organization's own stated mission and values. In addition, organizations could use the action guide to evaluate whether policies made in accordance with it are carried out consistently by front-line staff.

## Conclusion

Baum and colleagues (2007) argue that the value of providing a tool for ethical decision making is in helping public health practitioners clarify the ethical tensions in their work, balance the exclusive use of economic analysis, and promote the explicit analysis of values and transparency.<sup>19</sup> These same benefits can be expected from a tool developed for community-based healthcare organizations. In this paper we have drawn upon our prior empirical research<sup>20</sup> to evaluate, organize, and specify applicable elements of existing conceptual frameworks, so as to provide comprehensive, actionable guidance for resource allocation decision making that affects healthcare services available to members of community-based healthcare organizations. The action guide presented here represents a first step toward providing community-based healthcare organizations with a conceptually grounded, empirically informed framework for ethical decision-making.

## References

1. Lewin Marion and Institute of Medicine (U.S.), *America's Health Care Safety Net Intact but Endangered* (Washington D.C.: Institute of Medicine; National Academy Press, 2000).
2. Danis Marion , Clancy Carolyn , and Churchill Larry R. , *Ethical Dimensions of Health Policy*, 1st ed. (Oxford University Press, USA, 2005); Daniels Norman , Light Donald W. , and Caplan Ronald L. , *Benchmarks of Fairness for Health Care Reform* (Oxford University Press, USA, 2009)Powers Madison and Faden Ruth , *Social Justice: The Moral Foundations of Public Health and Health Policy*, 1st ed. (New York, NY: Oxford University Press, USA, 2006)Ruger Jennifer Prah *Health and Justice Social*, 1st ed. (Oxford University Press, USA, 2010)Prah Ruger Jennifer , "Ethics in American Health 1: Ethical Approaches to Health Policy," *American Journal of Public Health* 98, no. 10 (10 2008): 1751–56, doi:10.2105/AJPH.2007.12134318703449Kenny Nuala and Giacomini Mita , "Wanted: A New Ethics Field for Health Policy Analysis," *Health Care Analysis: HCA: Journal of Health Philosophy and Policy* 13, no. 4 (12 2005): 247–60, doi:10.1007/s10728-005-8123-316435463Jecker Nancy S , "A Broader View of Justice," *The American Journal of Bioethics: AJOB* 8, no. 10 (10 2008): 2–10, doi:10.1080/1526516080247841219003692Baerøe Kristine , "Priority Setting in Health Care: On the Relation between Reasonable Choices on the Micro-Level and the Macro-Level," *Theoretical Medicine and Bioethics* 29, no. 2 (2008): 87–102, doi:10.1007/s11017-008-9063-318528781Bayer R , "Health Promotion: Ethical and Social Dilemmas of Government Policy.," *Health Affairs* 5, no. 2 (1986): 72–853744277Cappelen Alexander W and Norheim Ole Frithjof , "Responsibility, Fairness and Rationing in Health Care," *Health Policy (Amsterdam, Netherlands)* 76, no. 3 (5 2006): 312–19, doi:10.1016/j.healthpol.2005.06.013Cookson R , McCabe C , and Tsuchiya A , "Public Healthcare Resource Allocation and

- the Rule of Rescue,” *Journal of Medical Ethics* 34, no. 7 (7 2008): 540–44, doi:10.1136/jme.2007.02179018591290
- Daniels N , “Benchmarks of Fairness for Health Care Reform: A Policy Tool for Developing Countries,” *Bulletin of the World Health Organization* 78, no. 6 (2000): 740–5010916911
- Edgar A , “Health Care Allocation, Public Consultation and the Concept of ‘Health,’” *Health Care Analysis: HCA: Journal of Health Philosophy and Policy* 6, no. 3 (9 1998): 193–98, doi:10.1007/BF0267810410185170
- Friedman LH and Savag GT , “Can Ethical Management and Managed Care Coexist?,” *Health Care Management Review* 23, no. 2 (1998): 56–629595310
- Goold SD , “Allocating Health Care: Cost-Utility Analysis, Informed Democratic Decision Making, or the Veil of Ignorance?,” *Journal of Health Politics, Policy and Law* 21, no. 1 (1996): 69–98
- Goold Susan Dorr , and Nancy M , “Where Are We in the Rationing Debate?,” *BMJ (Clinical Research Ed.)* 337 (2008): a2047
- Hoedemaekers Rogeer and Dekkers Wim , “Key Concepts in Health Care Priority Setting,” *Health Care Analysis: HCA: Journal of Health Philosophy and Policy* 11, no. 4 (12 2003): 309–23, doi:10.1023/B:HCAN.0000010060.43046.0514769013
- Keren Ron and Littlejohns Peter , “Consideration of Social Values in the Establishment of Accountable Care Organizations in the USA,” *Journal of Health Organization and Management* 26, no. 3 (2012): 384–8922852460
- McCullough Laurence B , “An Ethical Framework for the Responsible Leadership of Accountable Care Organizations,” *American Journal of Medical Quality: The Official Journal of the American College of Medical Quality* 27, no. 3 (6 2012): 189–94, doi:10.1177/106286061142122622114154
- Olsen JA , “Theories of Justice and Their Implications for Priority Setting in Health Care,” *Journal of Health Economics* 16, no. 6 (12 1997): 625–3910176776
- Powers M , “Justice and the Market for Health Insurance,” *Kennedy Institute of Ethics Journal* 1, no. 4 (12 1991): 307–2310115860
- Ruger Jennifer Prah , “Health Capability: Conceptualization and Operationalization,” *American Journal of Public Health* 100, no. 1 (1 2010): 41–49, doi:10.2105/AJPH.2008.14365119965570
- Saltman RB and Ferroussier-Davis O , “The Concept of Stewardship in Health Policy,” *Bulletin of the World Health Organization* 78, no. 6 (2000): 732–3910916910
- Wikler D , “What Has Bioethics to Offer Health Policy?,” *The Milbank Quarterly* 69, no. 2 (1991): 233–511791789
- Biron Laura , Rumbold Benedict , and Faden Ruth , “Social Value Judgments in Healthcare: A Philosophical Critique,” *Journal of Health Organization and Management* 26, no. 3 (2012): 317–30.22852454
3. Harrison Krista Lyn and Taylor Holly A. , “Organizational Values in the Provision of Access to Care for the Uninsured,” *AJOB Empirical Bioethics* 7, no. 4 (October 1, 2016): 240–50, doi:10.1080/23294515.2016.117007528781981
  - Harrison Krista Lyn and Taylor Holly A. , “Healthcare Resource Allocation Decisions Affecting Uninsured Services,” *Journal of Health Organization and Management* 30, no. 8 (11 21, 2016): 1162–82, doi:10.1108/JHOM-01-2016-0003.27934550
  4. Harrison and Taylor, “Organizational Values in the Provision of Access to Care for the Uninsured”; Harrison and Taylor, “Healthcare Resource Allocation Decisions Affecting Uninsured Services.”
  5. Harrison Krista Lyn , *Forks in the Road: Organizational Values and Health Care Resource Allocation Decisions in the Provision of Access to Care for the Uninsured* (Johns Hopkins University, 2013), [https://catalyst.library.jhu.edu/catalog/bib\\_4808172](https://catalyst.library.jhu.edu/catalog/bib_4808172).
  6. Kass NE , “An Ethics Framework for Public Health,” *American Journal of Public Health* 91, no. 11 (11 2001): 1776–82.11684600
  7. Kenny and Giacomini , “Wanted.”
  8. Gallagher John A and Goodstein Jerry , “Fulfilling Institutional Responsibilities in Health Care: Organizational Ethics and the Role of Mission Discernment,” *Business Ethics Quarterly: The Journal of the Society for Business Ethics* 12, no. 4 (10 2002): 433–50.12708455
  9. Kass , “An Ethics Framework for Public Health”; Childress James F , “Public Health Ethics: Mapping the Terrain,” *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics* 30, no. 2 (2002): 170–78
  - Baum Nancy M , “Looking Ahead: Addressing Ethical Challenges in Public Health Practice,” *The Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics* 35, no. 4 (2007): 657–67, 513, doi:10.1111/j.1748-720X.2007.00188.x
  - Nuffield Council on Bioethics, “Public Health: Ethical Issues” (London: Nuffield Council on Bioethics, 2007), <http://www.nuffieldbioethics.org/go/ourwork/publichealth/introduction>
  - Marckmann Georg , “Putting Public Health Ethics into Practice: A Systematic Framework,” *Frontiers in Public Health* 3 (2015): 23, doi:10.3389/fpubh.2015.00023.25705615
  10. Daniels N and Sabin J , “The Ethics of Accountability in Managed Care Reform,” *Health Affairs (Project Hope)* 17, no. 5 (10 1998): 50–649769571
  - Caplan RL , Light DW , and Daniels N ,

“Benchmarks of Fairness: A Moral Framework for Assessing Equity,” *International Journal of Health Services: Planning, Administration, Evaluation* 29, no. 4 (1999): 853–69 Emanuel Ezekiel J. , “Justice and Managed Care: Four Principles for the Just Allocation of Health Care Resources,” *The Hastings Center Report* 30, no. 3 (6 2000): 8–1610862365Wynia Matthew K , “Improving Fairness in Coverage Decisions: Performance Expectations for Quality Improvement,” *The American Journal of Bioethics: AJOB* 4, no. 3 (2004): 87–100, doi: 10.1080/1526516049049767816192158Clark Sarah and Weale Albert , “Social Values in Health Priority Setting: A Conceptual Framework,” *Journal of Health Organization and Management* 26, no. 3 (2012): 293–316.

11. Ozar David , “Organizational Ethics in Health Care: Toward a Model of Ethical Decision-Making by Provider Organizations,” National Working Group Report (Institute for Ethics, American Medical Association, 2000); Ana Smith Iltis, “Values Based Decision Making: Organizational Mission and Integrity,” *HEC Forum: An Interdisciplinary Journal on Hospitals’ Ethical and Legal Issues* 17, no. 1 (3 2005): 6–1715957265Winkler Eva C and Gruen Russell L , “First Principles: Substantive Ethics for Healthcare Organizations,” *Journal of Healthcare Management / American College of Healthcare Executives* 50, no. 2 (4 2005): 109–19; discussion 119–2015839325Nelson William A and Wadsworth Eric , “The Ethical Basis for Creating ACOs. Organizations Have a Moral Imperative to Deliver Cost-Effective, High-Quality and Safe Healthcare,” *Healthcare Executive* 25, no. 4 (8 2010): 44, 46–47.20954535
12. Harrison and Taylor, “Organizational Values in the Provision of Access to Care for the Uninsured”; Harrison and Taylor, “Healthcare Resource Allocation Decisions Affecting Uninsured Services.”
13. Marckmann , “Putting Public Health Ethics into Practice.”
14. Daniels N , “Accountability for Reasonableness,” *BMJ (Clinical Research Ed.)* 321, no. 7272 (November 25, 2000): 1300–1301.
15. Burke Nancy J. , “Theorizing Social Context: Rethinking Behavioral Theory,” *Health Education & Behavior: The Official Publication of the Society for Public Health Education* 36, no. 5 Suppl (10 2009): 55S–70S, doi:10.1177/1090198109335338.19805791
16. Harrison and Taylor, “Healthcare Resource Allocation Decisions Affecting Uninsured Services.”
17. Harrison , *Forks in the Road*.
18. Ballantine Jennifer , Harrison Krista L. , and Kirk Timothy W. , “Guide to Organizational Ethics in Hospice Care” (Alexandria, VA: National Hospice and Palliative Care Organization, 1 2016).
19. Baum , “Looking Ahead.”
20. Harrison and Taylor, “Organizational Values in the Provision of Access to Care for the Uninsured”; Harrison and Taylor, “Healthcare Resource Allocation Decisions Affecting Uninsured Services.”
21. Baum , “Looking Ahead,” 662.
22. Iltis, “Values Based Decision Making,” 7.
23. *Ibid.*, 15.
24. *Ibid.*
25. Marckmann et al., “Putting Public Health Ethics into Practice,” 5.
26. *Ibid.*
27. Childress et al., “Public Health Ethics,” 172.
28. Caplan Light , and Daniels, “Benchmarks of Fairness,” 863.
29. Clark and Weale , “Social Values in Health Priority Setting,” 296.
30. Marckmann et al., “Putting Public Health Ethics into Practice,” 5.
31. Baum et al., “Looking Ahead,” 662.
32. Caplan Light , and Daniels, “Benchmarks of Fairness,” 857.
33. Nuffield Council on Bioethics, “Public Health: Ethical Issues,” 26.
34. Marckmann et al., “Putting Public Health Ethics into Practice,” 3.
35. Wynia et al., “Improving Fairness in Coverage Decisions,” 95.
36. Clark and Weale “Social Values in Health Priority Setting,” 309.
37. *Ibid.*, 306.
38. Marckmann et al., “Putting Public Health Ethics into Practice,” 3.

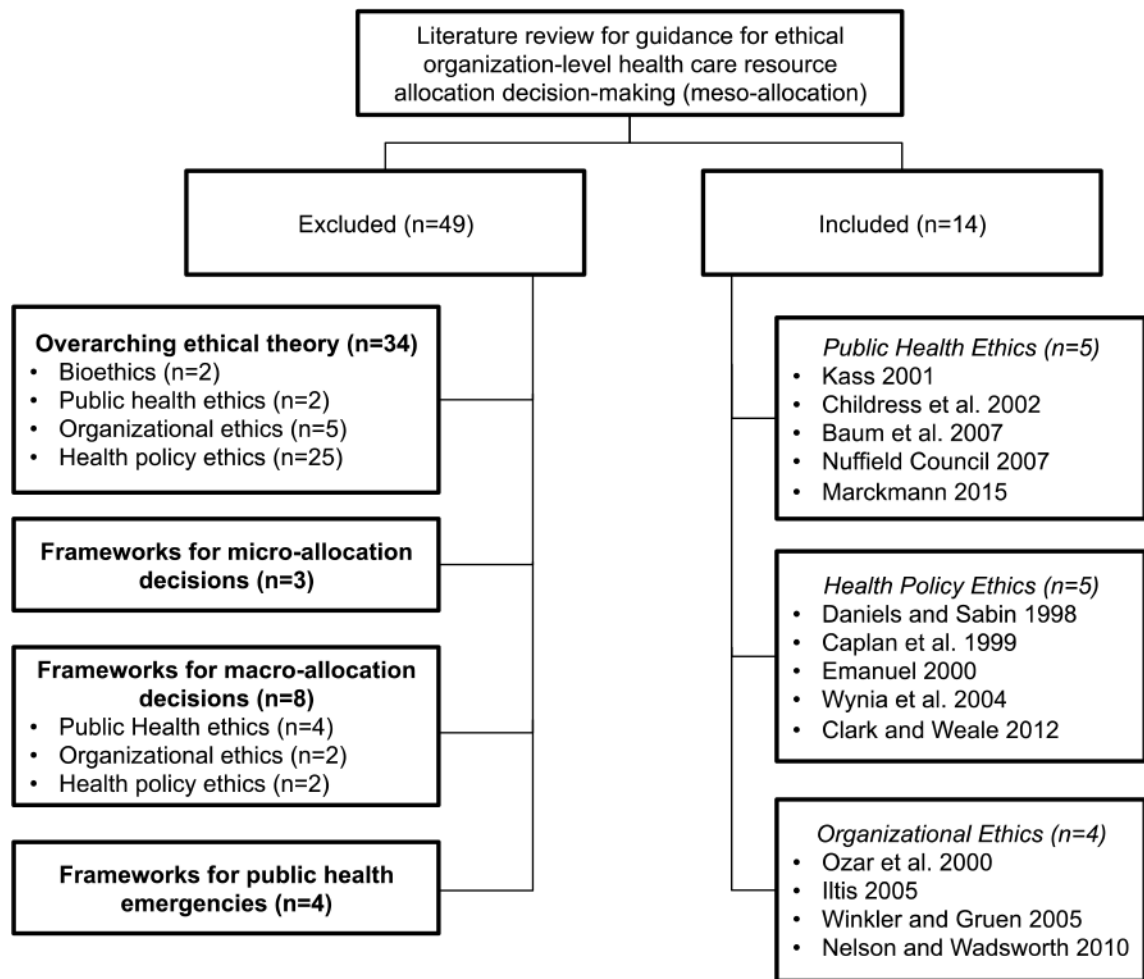
39. Ibid.
40. Clark and Weale , “Social Values in Health Priority Setting,” 310.
41. Caplan Light , and Daniels, “Benchmarks of Fairness,” 858.
42. Kass , “An Ethics Framework for Public Health,” 1781.
43. Ozar et al., “Organizational Ethics in Health Care: Toward a Model of Ethical Decision-Making by Provider Organizations,” 14.
44. Ibid., 13.
45. Ibid.
46. Baum et al., “Looking Ahead,” 662.

Author Manuscript

Author Manuscript

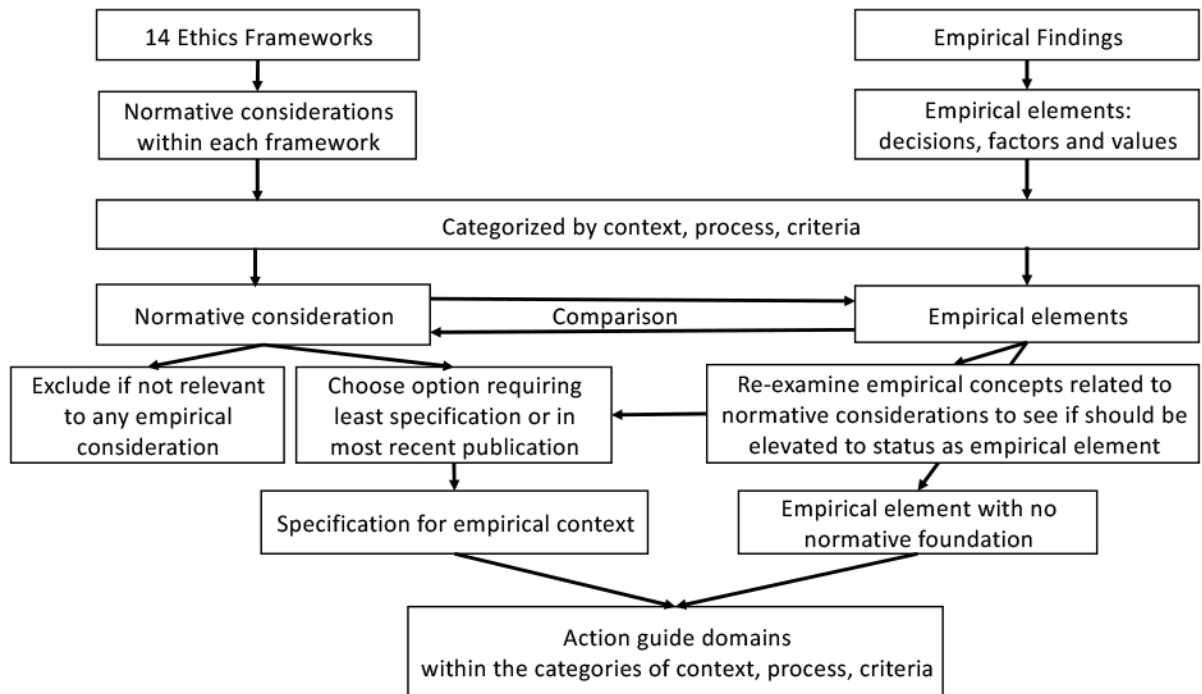
Author Manuscript

Author Manuscript



**Figure 1:** Summary of inclusion/exclusion criteria for literature review and selected frameworks





**Figure 2.**  
Process of Creating Action Guide

**Table 1:**

## Comparison of Empirical Findings &amp; Normative Considerations

Empirical data on factors involved in resource allocation decisions	Ethics Framework	Normative consideration from Framework
<i>Relevant to context of the decision</i>		
Trends at the local, state, or federal level (e.g. One site founded during a recession and election health reform debate. Site 2: movement toward managed care, attention to pill mills and narcotics addiction)		None
Political factors (e.g. not allowing undocumented or people over 500% of the federal poverty level to be eligible at site 1 or covering birth control at site 2 due to perception or statement that doing so would jeopardize the program)	Baum 2007	“Consider political feasibility and community acceptance” <sup>21</sup>
Economic factors (e.g. When financial viability was threatened, organizations created policies to limit access to either a certain number of people (site 1) or for a certain amount of participation (site 2))		None
Mission referenced at both sites as a source of core values and goals	Itlis 2005	“establish a mission, i.e., a set of fundamental commitments and values” <sup>22</sup> Understand “the implications of those commitments for various aspects of organizational life” <sup>23</sup>
<i>Relevant to the process by which the decision will be made</i>		
Common value of “organizational excellence” across sites defined as acting in a way that is aligned with their values, e.g. preserving access to care for the most poor or ill members even during organizational financial hardship	Itlis 2005	Integrate “organizational mission into decisions at all levels of an organization” Develop “a plan to resolve situations in which an organization’s values call it to act in incompatible ways” <sup>24</sup>
Varied stakeholders were recruited to advisory boards at both sites, including clinicians, members, local business leaders	Marckmann 2015	“Populations affected by the...intervention should be able to participate in the decision about the implementation” <sup>25</sup>
Participants referred to a goal of making decisions transparent	Marckmann 2015	“Decision process including database and underlying normative assumptions should be transparent and public” <sup>26</sup>
Participants believed that their members should be treated decently, with compassion, respect, and dignity, and that members should be empowered.	Childress 2002	“Building and maintaining trust” “Keeping promises and commitments” <sup>27</sup>
Every participant explicitly discussed tradeoffs made during decision-making processes	Caplan 1999	“Comparability...all funds expended for health care should be explicitly gathered into a budget so that they can be weighed against other, competing social needs” <sup>28</sup>
Participants discussed the importance of making responsible decisions and using public dollars wisely; subdomain within common organizational value of stewardship	Clark & Weale 2012	“Accountability means being answerable to those who are affected by decisions made about health priorities – typically patients and the public – for how health resources are allocated.” <sup>29</sup>
Participants discussed how several decisions were revised as data or conditions changed	Marckmann 2015	“Implementations of ... interventions should be open for revision (e.g. if data basis changes or certain aspects have been neglected)” <sup>30</sup>
Participants discussed how decisions were based on evidence about the characteristics of the county uninsured, best practices in health care delivery, and data from utilization review before and after policy changes	Baum 2007	“Demonstrate evidence of need and effectiveness of actions” <sup>31</sup>
<i>Relevant to the criteria by which options will be evaluated</i>		
Core value of ensuring or facilitating access to health care for members, e.g. based on belief in universal right to affordable care (site 1) or maximizing access to a temporary bridge to services (site 2)	Caplan 1999	“Universal access – coverage and participation: Any fair health care system must make all needed and effective services equally available to everyone regardless of their health conditions or risks” <sup>32</sup>

Empirical data on factors involved in resource allocation decisions	Ethics Framework	Normative consideration from Framework
Participants said they wanted to provide access to care that was described as: high quality, preventive, primary comprehensive, coordinated, medical-home based and culturally appropriate	Nuffield 2007	"Ensure that people have appropriate access to medical services" <sup>33</sup>
Participants discussed potential impacts of decisions on various desired outcomes, e.g. reducing inappropriate use of pain management specialists or changing mandated use of health coaching service	Marckmann 2015	"Expected health benefits for target population <ul style="list-style-type: none"> <li>• range of expected effects (endpoints)</li> <li>• magnitude and likelihood of each effect</li> <li>• strength of evidence for each effect</li> <li>• public health/practical relevance of the effects</li> <li>• incremental benefit compared to alternative interventions"<sup>34</sup></li> </ul>
Sites sought to provide culturally appropriate care, for example, Site 1 modified health coaching program to more effectively serve those with limited English proficiency but who wanted to participate	Wynia 2004	"Compassionate. The design and administration of health benefits should be flexible, responsive to individual values and priorities, and attentive to those with critical needs and special vulnerabilities" <sup>35</sup>
Subdomain of organizational value of service to others was to providing a safety net and helping the most vulnerable people, e.g. even when limiting access to care, Site 2 made exceptions for the very least-well-of, ensuring pain management is still available for acute needs, and chronic care available to those with blood cancer or sickle cell	Clark & Weale 2012	"The principle of solidarity implies a commitment to the idea that all members of society will stand together and will not leave anyone behind, no matter how needy or disadvantaged" <sup>36</sup>
The organizational value of fairness encompassed a goal to treat individual members or providers the same way as other members or providers, e.g. Site 1 revised a policy mandating involvement in health coaching because members with limited English proficiency could not participate	Clark & Weale 2012	Justice/equity: "patients who are alike in relevant respects should be treated the same, and those who are unlike in relevant respects should be treated in appropriately different ways" <sup>37</sup>
Participants described considering who was in need that might not receive care, e.g. if colonoscopies not covered (site 1), if chronic pain management services were completely excluded (site 2)	Marckmann 2015	"Potential harm and burdens <ul style="list-style-type: none"> <li>• range of potential negative effects (endpoints)</li> <li>• magnitudes and likelihood of each negative effect</li> <li>• strength of evidence for each negative effect</li> <li>• public health (practical) relevance of negative effects</li> <li>• burdens and harms compared to alternative interventions"<sup>38</sup></li> </ul>
One domain within a common organizational value of service to others was empowering members to be self-reliant	Marckmann 2015	"Impact on autonomy <ul style="list-style-type: none"> <li>• health-related empowerment (e.g. improved health literacy)</li> <li>• respect for individual autonomous choice (e.g. possibility of informed consent, least restrictive means)</li> <li>• protection of privacy and confidentiality (e.g. data protection)"<sup>39</sup></li> </ul>
Common organizational value of supporting member independence and self-sufficiency	Clarke and Weale 2012	Autonomy "used to refer to the ability of individuals to be self-directing and make decisions for themselves about important matters....those choices will be one's own and thus also one's own responsibility" <sup>40</sup>
Affordability was a subdomain within the common organizational value of access to care	Caplan 1999	"Equitable financing – by ability to pay: All direct and indirect payments and out-of-pocket expenses scaled to household budget and ability to pay" <sup>41</sup>
A subdomain of organizational value of fairness included a goal to treat individual providers alike, e.g. Site 2 wanted to ensure that the provision of care for the indigent was spread evenly across their provider networks.	Kass 2001	"How can the benefits and burdens of a program be fairly balanced?" <sup>42</sup>
Common organizational value of community wellbeing compromised a belief that providing people access to care would benefit the health of the entire community	Ozar 2000	Benefit to the community <sup>43</sup>
One domain within a common organizational value of service to others was advocating for public policies that would benefit their members	Ozar 2000	Advocacy for social policy reform <sup>44</sup>
Decisions always included consideration of the impact of the organization's financial viability,	Ozar 2000	Organizational solvency/survival <sup>45</sup>

Empirical data on factors involved in resource allocation decisions	Ethics Framework	Normative consideration from Framework
solvency or sustainability (subdomain within common organizational value of stewardship), e.g. site 2 was created to sustainably fund indigent healthcare		
Sites constantly considered where to set limits on access to services based on need, costs, and degree of staff resources needed; e.g. Site 1 decided to pay for colonoscopies because of substantial need in population and lack of access otherwise	Baum 2007	"Assess expected efficiencies and costs associated with proposed action" <sup>46</sup>

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

**Table 2:**

Action guide for resource allocation and policy decision-making affecting healthcare services in community-based healthcare organizations

<b>Consider the context of the decision</b>
1. What are the fundamental commitments, goals and values of the organization? How do they impact various aspects of the community health organization?
2. Are there policy priorities at the local, state, or federal level relevant to the decision?
3. Are there economic factors relevant to this decision that could impact the process or outcome of the decision?
4. Are there political factors that could impact the community feasibility and acceptability of the decision?
<b>Consider the process by which the decision will be made</b>
5. How will the decision-making process enable the participation and contribution of affected stakeholders with different interests?
6. What is the quality of the data and evidence used in analyzing the problem or solution?
7. How will tradeoffs be explicitly examined and compared, for example, using a budget that includes all funds and resources?
8. How will the decision-making process and result be made publicly transparent, including data and assumptions?
9. How this decision build or maintain trust with members and other stakeholders, for example, by treating them with compassion, respect, dignity and decency?
10. How will the decision-making process reflect organizational excellence and values, goals and commitments? How will situations be resolved in which an organization's values call it to act in incompatible ways?
11. To whom will we be accountable for the process or outcome of the decision, justifying and taking responsibility for activities and prioritizations?
12. How will the decision be revised if conditions or data change?
<b>Consider the criteria by which you will choose between options or evaluate the quality of options</b>
13. How will this decision impact access to care given that all members should have access to comprehensive and uniform benefits?
14. To ensure ethical stewardship of our resources, what are the expected efficiencies and costs associated with proposed action? Where should we set limits on services?
15. What is the expected clinical effectiveness of interventions, including expected health benefits or care outcomes? How will the decision impact the likelihood of effectively achieving those goals?
16. How will we define what type and quality of care will be available to ensure all members have appropriate access to medical services?
17. How will this decision impact our ability to serve the diverse needs and preferences of our members given that the care provided to members should be compassionate, flexible, responsive to individual values and priorities, and attentive to those with critical needs or special vulnerabilities?
18. Does this decision prioritize or impact the most vulnerable population served, especially in terms of those who are the least well-off in terms of health?
19. Will this decision cause burdens or harms to any subpopulation of members?
20. Will this decision treat similar members alike? How are considerations such as age, personal responsibility, lifestyle choices or family situation taken into account implicitly or explicitly in priority setting? Are subpopulations of members treated fairly by this decision?
21. Will this decision help members be self-directing and achieve independence by taking responsibility for their own health or health outcomes?
22. Will the decision empower members or help them achieve their desired ends? Does it respect individual autonomous choices of members?
23. Will this decision maintain or improve equitable financing and affordability of healthcare for members by ensuring costs to members match their ability to pay?
24. Will this decision change the organization's financial viability, solvency or sustainability?
25. Will the benefits and burdens of this decision be fairly balanced, for example, across clinician/provider partners?
26. How will this decision benefit the health of the community?
27. Will the decision promote social policy reform or wellness broadly?