The Challenge of Resource Allocation

Wise Decisions Require Organizations to Ask Difficult Questions

BY BR. TOM MADDIX, CSC

Br. Maddix, formerly vice president, organizational advancement, Caritas Health Group, Edmonton, Alberta, is now vice president, mission, ethics, and spirituality, Providence Health Care, Vancouver, British Columbia. He is the author, with Ian C. Soles, of Journey to Wholeness: Healing Body, Soul and Mind *(Novalis Publishing, Montreal, 2003).*

The just and fair allocation of resources has always required integrity, trust in Providence, and a willingness to grapple with the unknown. Today, health care providers struggle to make good decisions in the face of high public expectations concerning service; a shrinking public purse; and mounting costs for labor, pharmaceuticals, and technology.

Caritas Health Group, Edmonton, Alberta, recently became determined to make its resource-allocation process as transparent as possible, thereby reinforcing the justice and fairness of the decisions involved. Before describing this initiative, however, I need to say something about the larger problem.

The Catholic Tradition

"Tough Choices," the title given to a recent conference in Alberta on resource allocation, captures the dilemma of boards and executives in the current health care environment. Good decisions do not appear in a vacuum. They flow from the intuitions, values, and commitment of the people charged with making them. Self-knowledge—coupled with a willingness to grapple with a decision's possible impact on individuals, services, and the organization as a whole—is a key component of healthy decision making. Clearly, decisions will be only as healthy as the people who make them.

Good decision making also flows from an ability to articulate what we know and do not know about a given topic or situation. Often, it's what we do not know that gives us the most important clue to the value of a given decision. We may, when faced with significant financial challenges, discover some "easy targets." However, the easy-target approach frequently has unfortunate consequences. Instead of going for the easy solution, we should make decisions aligned with our strategic directions, our legacy, and mission.

Resource allocation has been at the heart of Catholic health care since its inception. Making difficult choices has been a hallmark of our history. Because we have chosen to respond to the needs of the poorest and most vulnerable people in our midst, we have always had to be good stewards of the resources available to us. Tough choices have continually dominated our organizational lives, and things are no different today in that respect. What has changed is the diversity of the decision makers in our ministry. Diversity in the decision makers' culture, education, personal values, and understanding of Providence and how God engages humanity—together, of course, with a variety of market forces both internal and external to the organization—challenge today's faith-based providers to adopt a more intentional way of decision making.

Resource Allocation and Caritas

Although Catholic health organizations in North America share rich traditions in ethical reflection and guidelines for good decision making—notably the *Health Ethics Guide,* in Canada, and the *Ethical and Religious Directives for Catholic Health Care Services,* in the United States—vital decisions are made by groups of people brought together for that purpose. Catholic ethical reflection is rooted in an understanding of God, God's relationship to humanity, the dignity of the person, and the solidarity of all people grounded in a biblically living faith. When we grapple with difficult decisions concerning resource allocation, we do so in light of who we are. Our organizations are neither for-profit businesses nor privately held corporations—they exist, rather, to reveal hope, make tangible the healing mission of Jesus, to continue the legacy of service to the common

good established by our founding religious congregations.

Caritas is a Catholic organization that, funded through the provincial government via a regional health authority, provides acute and continuing care services in a large metropolitan area. In 2002, Caritas began a process intended to deepen and clarify our decision making concerning resource allocation. We convened a series of focus groups dedicated to asking, "How are we doing in living our mission in terms of ethical reflection?" From these discussions, we learned a great deal about how the participants viewed Caritas. All of the respondents—board members, senior executives, managers, and frontline staff—reported that they were unsure how resource allocation decisions were made. Caritas's board and senior executives, meeting later in a management forum, promised to make the decision making involved in resource allocation transparent.

A Task Force Is Formed

Caritas's senior executives formed a task force to develop a transparent decision-making process. I was appointed the convener of the task force, which included leaders from the group's clinical, therapeutic, hospitality, and security services and its physical plant and planning departments.

We began our work by reading a document called *Guiding Principles*, which had been developed by Caritas's senior executives and approved by the board as part of the group's strategic directions (see **Box**, p. 62). "These are nice," task force members said, "but they're a little like 'motherhood and apple pie' statements." The group decided that the principles needed to be fleshed out and made more concrete.

I asked task force members to explain how resource-allocation decisions were made in *their* departments. From this discussion, we drew up a list of eight questions to be asked of the Caritas groups that make resource-allocation decisions. The questions were:

1. How will the proposed decision advance Caritas's overall mission, vision, values, and ethical framework?

2. Does the proposed decision fit within Caritas's overall, agreed-upon corporate priorities and strategic directions?

- Does it fit continuing care priorities?
- Does it fit community hospital priorities?
- Does it fit provincially unique programs (i.e., those funded directly by the province, Alberta in this case), such as hyperbaric oxygen, palliative care, craniofacial osseointegration and maxillofacial prosthetic rehabilitation unit, mental health, and intensive care nursery?*
- Does it fit agreed-upon regional/capital health authority priorities for service, thereby avoiding duplication of services?
- Does it fit provincial or regional funding formulae for continuing care and acute care services?

3. Is this decision based upon quantitative/qualitative evidence and best practice?

4. Can everyone "at the table" explain to others how and why the decision was made even if they do not agree with it?

5. Were the right people (e.g., clinical, physical plant, finance, educational partners, and hospitality services) engaged in the decision?

6. What are the risks/benefits of the decision on the overall good of the organization (staff and patients/residents)?

7. Do we know the impact of this decision upon the people we serve (patients/residents and their families and visitors)?

8. What is the consequence (short- and long-term) if we do not make the decision?

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A Living Document

Using these questions as a foundation, the task force wrote a draft statement concerning resource allocation. The question we then asked ourselves was: How do we make this a living document? Do we ask managers and others to sign off every time they make a significant resource decision?

*Health care in Canada is funded by government, sometimes at the provincial level, sometimes through what are known as "health regions." This question and the next two involve Canadian funding practices, which differ from those found in the United States.

Or do we trust that people will intuitively make the right decision, using these questions as guidelines as they go through the resource-allocation process?

We chose the latter method. We also decided to write a preamble to the document, grounding it in the definitions and values outlined in the *Health Ethics Guide*, particularly the statement: "Organizations are encouraged to develop a suitable protocol to address the rationing of resources."[1]

In 2003, the task force finished writing the document and shared it with various stakeholders in the organization. However, the danger with any document is that its authors will feel that the job is finished once the words have been put on paper. But the paper has value only if it *lives*. We knew that, to make Caritas's resource-allocation guide a living document, we would need to continually refer to it as we sought to be responsible stewards and manage and plan our finances throughout the year. We would also need to review past decisions and determine which of those we had handled well and which we needed to improve on. In some cases, we would need to alter decisions that later appeared to be mistaken.

Decisions concerning the allocation of resources create change. As the U.S. community organizer Saul Alinsky once put it, "Change means movement. Movement means friction."[2] How we at Caritas live and grow through the "friction" caused by the resource-allocation decisions will test the vitality of our shared mission, vision, and values as well as our organizational integrity.

The path ahead for faith-based organizations demands intentionality grounded in the ability to pose the tough questions; seek input from colleagues; and act upon it with sincerity, integrity, and a clear self-knowledge. Like the founders of Catholic health care organizations throughout North America, we need to continually root ourselves in a compelling vision of how God acts, and then listen carefully to what God asks of us today. Sr. Mary Joseph Rogers, MM, the foundress of the Maryknoll Sisters, wrote to her colleagues, "God has yet a great work for us to do, but the realization of this vision depends on you and me as individuals and on our cooperation. Do we love enough, do we work enough, do we pray enough, do we suffer enough? The future depends on our answer."[3]

Sr. Mary Joseph's words remain as excellent advice to us as we seek to shape Catholic health care today. We too need to ask, Do we love enough? Pray enough? Work enough? We are people asked to make tough choices about resource allocation, and the future depends on how we answer these questions.

Caritas's "Guiding Principles"

Recognizing the unlimited possibilities and demands on our limited resources, we must be strategic and intentional in our decision making. We will be guided by the following principles in building the continuum of care.

We will:

- Respond to needs that no one else will address and be a voice for people who cannot speak for themselves
- Ensure that the common good of all people is served
- Support programs that are congruent with our roots, mission, and values
- Work with groups that share our values and vision for the future
- Search for and engage in opportunities that hold the greatest potential for strengthening our mission/vision/values in our community
- Serve the broader needs of our immediate communities/neighborhoods and the more specific needs of the broader community
- Ensure responsible stewardship
- Be innovative in our involvement, adopting different roles—advocate, catalyst, provider, partner—as appropriate
- Enhance the quality of life for people
- Increase hope

NOTES

1. Catholic Health Association of Canada, *Health Ethics Guide*, Ottawa, 2000, para. 135.
2. Alinsky is quoted in Joan Chittister, *Scarred by Struggle, Transformed by Hope*, William B. Eerdmans Publishing, Grand Rapids, MI, p. 21.
3. Michael Leach and Susan Perry, eds., *A Maryknoll Book of Prayer*, Orbis Books, Maryknoll, NY, 2003, p. 78.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2005