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MANAGEMENT, ETHICS AND THE ALLOCATION OF RESOURCES

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Health service managers have a responsibility to use resources responsibly (Ashcroft 1996). To say that managers should use resources 'responsibly' however tells us too little. What counts as responsible use? Presumably it implies at least that wastefulness should be avoided, but it does not signify anything about the criteria of distribution to be employed, in terms of effectiveness, efficiency or fairness. As one Chief Executive has pointed out, 'Each health authority will adopt its own methodology for allocating priorities and listen to a range of individuals and local organisations' (Ashcroft 1996: 4).

The question of criteria of distribution of health resources has received much attention from health economists, philosophers, health professionals and public policy-makers, but remains a contested area. This is partly because central concepts in the debate, such as 'justice' and 'equity' are themselves contested concepts. But there is also confusion because of the various levels at which decisions are and should be taken. Managers, in particular, are subject to competing demands, for example to respect budgets, to consult the public, to abide by the stated values of the service, whether they should become involved with individual cases or only with making decisions about services.

A 'MANAGEMENT' PERSPECTIVE?

We first have to be clear about what is meant by 'management' in this context. What I am concerned with is the management task of

taking decisions about commissioning and possibly disinvesting in services. The class of people responsible for this may be subject to change, for example as a result of government policy regarding the National Health Service (NHS), but the task of setting priorities remains. Some of these decision-makers may in fact be clinicians, but will be taking resource allocation decisions not *qua* clinicians, but wearing a management hat. Thus it is the activity rather than particular persons that is under discussion.

Chambers defines the manager as 'one who organises other people's doings'. If those people's doings were not worthwhile, the activity of the manager, similarly, would be worthless. Management has no intrinsic value of its own: it has only instrumental value, in so far as it contributes to the goals of the activity in question. Interesting questions arise in the discussion of what those goals are and/or should be. We cannot assume that the ethical manager is simply one who adopts morally acceptable means to achieve goals. Aristotle distinguished between mere cleverness, which is being good at working out ways to achieve objectives, and practical wisdom, which involves also seeing what the right ends are. He was making the point that there is a moral question to be asked about goals. In the present context it has been suggested that too little effort has been devoted to what the objectives of the health care system should be: 'You must first of all pick your social ethic. Only after you have done that can you discuss efficiency at all' (Uwe Reinhardt, quoted in Office of Health Economics 1997).

In practice, however, there is a question about the extent to which managers do or can consider questions of social ethics. Evidence suggests that decisions on, for example, disinvestment in existing service provision are likely to be guided not by the explicit choice of a social ethic so much as by the likelihood of political, public or pressure group resistance, or by the costly consequences in terms of unused plant and staff (Working Party on Priority Setting 1998). In the light of this, certain tactics, such as the use of waiting lists and transfer of responsibility to other services, for example social services, have proved popular, while commissioning agencies have nevertheless expressed interest in guidance on the principles to be invoked, especially with new developments and technologies (*ibid.*).

A good place to start in thinking about applicable principles for managers working in the NHS is to consider the goals of that service. Despite the frequently made comment that the NHS is in reality an illness service rather than a health service,

the goals to be considered must have something to do with health. But is it possible to be more specific? There is a question here about what the goals *are*, as determined by the government of the day, and what they *should* be. The latter provides an area for dispute between a community-centred and an individual-centred approach.

THE GOALS OF THE NHS

Anthony Culyer (1997) has argued that a principal objective of the NHS is maximising the health of the whole community. Maximising is about efficiency, not effectiveness. Effectiveness, says Culyer, differs from efficiency in taking no account of opportunity cost. Culyer acknowledges the is/ought dichotomy and says that a principal objective of the NHS *is* maximising the health of the whole community because there is ministerial authority for this. He also states that it *ought* to be a principal objective of the NHS on the basis of the following argument:

1 Flourishing is an ultimate good.
2 Good health is (in general) a necessary condition of flourishing.
3 Health care may be necessary (though not sufficient) for realising better health.

In point 2 the aim of the words in parenthesis is to acknowledge the exceptional cases of those who flourish despite what might be considerable degrees of ill health. In point 3, while it is clear that health care is not a sufficient condition of better health, given the number of determinants of health, it is also not possible to state that it is necessary, though in some circumstances it may be.

John Harris (1997) argues against this point of view on the grounds that maximising the health of the *whole* community may have the effect of systematically advantaging some sections of the community. For example, he says, if all seriously ill people were allowed to die, this might dramatically improve aggregate health. What should be the case is that each individual has an equal chance of flourishing. This implies that what the objective of the NHS should be (irrespective of what it actually is at any given time) is to offer beneficial health care on the basis of individual need.

There seems to be some agreement here on the idea that the objective of the NHS is to offer health care as a means to the promotion of flourishing, but there is disagreement as to whether

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this flourishing should be maximised over the whole community or whether the individual ought to be at the centre of decision-making.

What I want to suggest is that there are certain concepts used freely in the debate which are susceptible of different interpretation according to which of these approaches is taken; and that the actual policies of the day have a tendency to exploit these ambiguities. The manager's position is then very unclear. The value of ethical theory is not so much that it provides a source of guidance as to the 'right answers' in determining what the objectives of the NHS ought to be and, in the light of that, what services ought to be prioritised. It is rather that it sheds light on what actually is being demanded of management within a given system.

INDIVIDUALISM

What factors might be involved in an individual-centred approach to management decision-making? Certainly in the context of clinical decision-making there is a widespread perception that medical ethics is primarily about promoting the interest of the individual patient (and hence that 'priority setting' or 'rationing' is not an option) whether or not this is interpreted in terms of beneficence, non-maleficence, or autonomy. The fact that justice is the fourth of the 'four principles' approach, now very popular in biomedical ethics, perhaps to a certain extent acknowledges the competing claims of different patients. But there is still support for another principle, not one of the four, viz. the principle of rescue – that we should do all we can to save the individual life. The fact that there is strong intuitive support for this principle is apparent from the powerful effects of media presentations of individual cases, however irrational it may be that people are moved more by the one identifiable case than the deaths of a larger number of 'anonymous' people.

It has already been pointed out that managers are not making decisions in a clinical capacity, and although they may sometimes become involved in individual cases, we are primarily concerned with prioritising services. A decision about the latter, however, can sometimes lead to the well-publicised individual case where 'rescue' is pitted against the management decision. The principle of rescue is however only practicable when applied to a select number of (often very highly publicised) cases. It is increasingly recognised that it would not be feasible to 'do everything' to save every individual, although, on the other hand, it continues to be held that NHS

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funding is sufficient (Light 1997). The NHS White Paper (1997), acknowledging rising public expectations, says that they 'should be channelled into shaping services to make them more responsive to the needs and preferences of the people who use them' (1997: 7–8). It rejects the suggestion that the arguments in favour of rationing or charging are convincing. It is also committed to ending unfairness (1997: 13).

In such a situation, in what ways is it possible for the manager to adopt an ethical perspective, to strike a course between meeting demand and avoiding unfairness? Departing from the principle of rescue, the manager might turn to ways of assessing claims for resources on the basis of certain criteria of what is fair and just.

JUSTICE

The view that allocation should be according to need is a conception of justice that has a long tradition of support in the context of the provision of health services. The Dutch Health Council in its report *Choices in Health Care*, however, demonstrated very well how different actors in the debate have different perspectives on the concept of need. From the point of view of the individual, they suggested, individual goals determine need; the professionals (providers) argue for need as objectively determined by biomedical limitations; from the point of view of the community, however, inability to participate in society determines need (Health Council of The Netherlands 1992: 50). This suggests that a manager could put need at the centre of decision-making, but that he or she is unlikely to interpret it as a clinician might. So with respect to the question whether need counts as an individual-centred approach, there is an ambiguity over whether that is because the criterion used involves need as interpreted by the individual or the need *of* the individual as interpreted by someone else. 'Need' could also be part of a community-based approach. The NHS White Paper, in the statement that 'In the new NHS patients will be treated according to need and need alone' (1997: 13), is able to exploit this ambiguity.

There are, however, reasons why a manager might not want to use need as the primary factor in decision-making about resources. One is that it does not follow from the fact that we have identified needs (however that is done) that the resources are there to satisfy them. The second report of the Working Party on Priority Setting finds evidence of reluctance to discover unmet and unmeetable

needs (1998). It may still be necessary to prioritise between identified needs, unless we allow resource availability to have an influence in determining how we interpret the concept of need, which is to approach the issue from the wrong direction.

In such a situation a manager might turn to utilitarianism – in fact it might be suggested that a manager who is responsible for purchasing services for substantial sections of the population is bound to employ some version of utilitarianism. Utilitarianism includes both a concept of utility and a principle of maximisation. In other words, there is some conception of what counts as success, and a principle that we should have as much of it as possible. In the context of health care, what should this be? One of the attractions of the Quality Adjusted Life Year (QALY) was that it provided the possibility of both a clear and a numerical measure of success. Criticisms of it have been widespread, partly on the grounds that, as originally formulated, it took no account of equity in distribution. Work now centres on ways of factoring equity into outcome measures, but Culyer points out that equity may not be sufficiently served by maximising an equity-weighted outcome measure (1997). Also important is the attempt to move towards some equal distribution of health across the population as a whole. So maximising health for the community in some kind of utilitarian way may not be sufficient, although a measure of outcome born from this type of reasoning may be a valuable tool for the manager.

One criticism of utilitarian thinking of a fairly crude sort is that it is prepared to sacrifice the interests of individuals in the course of its maximising policy. This is part of the reason for public outrage at the stories of individuals in great distress who are apparently denied the treatment they need to survive. From another perspective utilitarianism itself can still be seen as an approach which puts the individual at the centre of decision-making. As Derek Parfit has put it, 'Each counts for one. That is why more count for more' (Parfit 1978: 301). Each person, or each person's equal interest, has equal weight. Ironically, the Working Party on Priority Setting finds few attempts to use utilitarian-type outcome measures for overall policy, such as ranking of services, though such measures might be used to assess an appropriate response in a particular individual case.

In thinking about individual cases, however, a complicating factor is the influence of the meritorian or desert conception of justice, which holds that what is fair is that individuals should be treated according to what they deserve. This leads to considerable

controversy in the health care context, on several different grounds. First, it might be argued that health care is the kind of good for which this kind of criterion is inappropriate; second, that it is unworkable, because it is doubtful that many of us could claim to be blameless; third, that health professionals should be making decisions on the basis of medical evidence and not on the grounds of moral desert. On the other hand, in Germany it has been argued that 'personal responsibility, not rationing, is the way forward', because rationing is too politically sensitive *(BMJ* 1997), while in The Netherlands it has been suggested that, although it is morally acceptable to encourage personal responsibility, responsibility cannot be used as a criterion in allocating treatment (Health Council of The Netherlands 1992).

Contest in this area takes place over whether certain sorts of judgement are *actually* made on the basis of moral or medical criteria. For example, a case reported in the *BMJ* described a girl denied a kidney transplant allegedly on the grounds of bad school behaviour and use of ecstasy (Dyer 1997). Her mother also had a history of drug misuse. The surgeon in question, however, defended her decision on medical grounds – namely that the chances of success were very low.

How might these considerations inform decisions about services rather than individuals? There could be a policy in a region that smokers will not be allocated certain kinds of treatment. Under one interpretation this can be viewed as a judgement on the moral responsibility of smokers. From another point of view it is an estimate of likely outcomes. In practice, of course, it is very unlikely that the grounds for a decision of this type can be isolated.

It is clear from this discussion that even if the stated goals of the service are to meet the needs of individuals, and that this is what they ought to be, there is scope for different interpretations. Moreover, it is desirable to have some way of prioritising between identified needs, which leads to consideration of competing conceptions of justice.

THE COMMUNITY APPROACH

If we turn to the view that the goals of the service are and should be concerned with the health of the community, the idea of need will be differently perceived. Although the NHS White Paper puts together the idea of tailoring the services to the needs of individual

patients with that of making them 'more responsive to the needs and preferences of the people who use them', the latter idea would not be incompatible, under some interpretations, with a community-based approach. Henk ten Have has pointed out that a communitarian perspective, although liable to be mistakenly identified with a utilitarian approach, is not in essence utilitarian. On the contrary, it is dependent on a 'normative, deontological framework defining the meaning of community interests' (ten Have 1993: 45). From this perspective values are not dependent upon individual interests, wants or needs but come from the community:

> the moral agent should not be viewed in an atomistic way, but rather as situated in a moral community from which he derives his moral identity, his substantial moral convictions and his sense of direction. The moral community provides the individual with a moral space within which he inevitably finds himself located, and from which he derives the resources by means of which moral problem situations can be evaluated.
>
> (Zwart 1993: 53–4)

So values are derived from practices and ways of living. When the community is the centre of decision-making, the responsibilities, rather than the rights, of the individual may be emphasised. The very sense of what is beneficial to the individual is likely to be different than according to an individualistic perspective.

What follows for the manager from this point of view? He or she has to try to determine what the values of the community are – to elucidate a communitarian consensus. The possibility of doing this is subject to the criticism that it is theoretically impossible in contemporary society.

> The dominant forms of public life – the market, bureaucracy, are incompatible with community in this sense. Those who have involved the concept against liberalism have simply evaded the central problem which liberalism is attempting to confront – the place of values in a value-free world.
>
> (Poole 1991: 88)

Zwart has argued that the liberal-communitarian opposition can be understood in terms of two different points of view: the willingness to intervene and the willingness to accept. From the liberal viewpoint

we are willing to intervene, to do what we can to save the individual – hence the intuitive support for the principle of rescue. From the communitarian perspective we are willing to accept that we cannot do everything. This is slightly misleading, however, because in the second alternative it is a very different matter to be in the position of the one who decides that he or she cannot offer help from being in the position of the individual who will not receive the help desired or needed. So there is an opposition both between the attitudes of the decision-makers and between the status of the potential patients in the two perspectives.

So the communitarian manager has to accept that there are limits, but seeks to elucidate the communitarian consensus on values to aid him or her in making allocation decisions. This, I suggest, is in accord with the contemporary trend towards consulting the public on rationing or priority setting, by citizens' juries and the like. Of course, in the light of Poole's points, a danger is that what might be gained is not a communitarian consensus but a utilitarian majority vote. But this is perhaps too pessimistic. Although consensus in contemporary society may not be readily available, it might be a mistake to think that it cannot be constructed (cf. Moon 1993) via consensus conferences, for example, provided that sufficient safeguards are put in place to minimise the risk of excluding less powerful voices from the process. Culyer argues that equity concerns are not exhausted by equity in distribution: procedures and processes too must be fair. The sorts of procedures he appears to have in mind include waiting times, but they should also include means of constructing consensus.

While consulting the public will be important in carrying out the responsibility of facilitating health care for the local population, Len Doyal and Ian Gough have a worry about the communitarian project carried out at local level:

> any local, community-based, small-scale form of need satisfaction can foster 'insider' conceptions of human need and inhibit the growth of generalisable notions based on a wider collective identity. . . . The dream of a community politics which could unite different groups . . . cannot be realised in the absence of precisely such a cross-cultural and cross-group source of identity as human need.
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> (Doyal and Gough 1991: 308–9)

What this section has shown is that the goals of meeting needs and consulting the public could be compatible with a communitarian approach rather than an individual-centred approach. The manager here in consulting the public would not be eliciting consumer preferences but elucidating a *consensus*.

AN ALTERNATIVE APPROACH: TWO TIERS AND VIRTUE ETHICS

Before drawing any conclusion about this debate it is worth noting a different trend in this context which would put yet another slant on the manager's consultation role. The NHS White Paper expresses support for universalism but there is a view that in Europe there is an inevitable move towards 'two-tier' health care systems – a basic package and supplementary systems. Sass has argued that in the old way of viewing health care systems, solidarity was appropriate as a principle (Sass 1995). In the new model, a triad of principles has taken its place: self-responsibility, solidarity and subsidiarity. At the level of the basic package, solidarity with those in need and distributive justice remain appropriate.

Beyond that, subsidiarity suggests that 'whatever the individual can do, should not be done by the state or by social institutions or uniform services'. This facilitates the notion of personal responsibility. Responsibility here should not be understood, however, in terms of the desert model of justice, but in terms of virtue ethics. According to Sass, in the old system, 'a patient's moral virtues were seen as limited mainly to compliance and hope'. In the new system, the patient is to be encouraged to an attitude of acceptance and to being responsible. This 'encouragement' would presumably require programmes of public awareness and reflection on what it is reasonable to expect health care to provide (Sass 1995).

How could the management perspective fit into this approach? Reinhardt has suggested a system where there could be a single-tier system funded from taxation, but an option to buy extra care, with the possibility of choosing between competing purchasers, based initially on current district health authorities. It would then be incumbent on these purchasers to give high quality information to potential clients, in addition to their obligation to manage the publicly funded service.

In a different context, the provision of information is recognised as an important objective by Culyer: 'improved health is not the

only business of the NHS. In relations with patients a common task in both primary and secondary care is to provide information – and no more' (1997). It is certainly the case that in some services, genetics services for example, the outcome aimed at may be more informed clients, rather than health gain as identified by some outcome measure, for example the QALY. In fact it has been a feature of genetics services that they have sought to distance themselves from objectives in terms of the health of the population. It is important therefore, for a number of reasons, that managers take on board the informational aspect of their role, in addition to maximising the health of the community or promoting the flourishing of the individuals within their sphere of influence.

CONCLUSION

Managers may have strategies, such as the use of waiting lists, to help them in allocating resources, but there is also an issue about ethical criteria in allocation. It is therefore useful to explore what ethical theory has to offer. Managers, however, have to take decisions within a number of constraints, the most obvious being the goals of the service as defined by the government of the day. These may be subject to change, but the concepts employed allow for varying interpretation under different ethical perspectives. The values inherent in the service (cf. Working Party on Priority Setting 1996: 11–12) have been stated to be equity, efficiency and responsiveness (developed into the principles of equity, public choice and effective use of resources), which seem under one interpretation to represent an attempt to negotiate between individual and community. Equity, although the meaning is contested, aims at a fair distribution between individuals as well as seeking to narrow the gap between the better and worse off. Efficiency pays regard to outcomes. Responsiveness is the value that reflects the importance assigned to consulting the population, which seems to be in accordance with the idea of establishing a consensus.

The White Paper, however, appears to be attempting to reinforce the importance of an individual-centred approach. In the light of this, it is necessary to consider what is the objective in consulting the public. It could be a way of establishing a community consensus, eliciting consumer preferences, or it could have an educative role. Thus, although the ethical manager operates within constraints in terms of stated goals, he or she has scope for various

interpretations. This is where the role of management overlaps with the discussion of what the goals of the health service *should* be, and this, rather than answering specific priority setting questions, is where ethical theory has a role to play.

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