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Converge3

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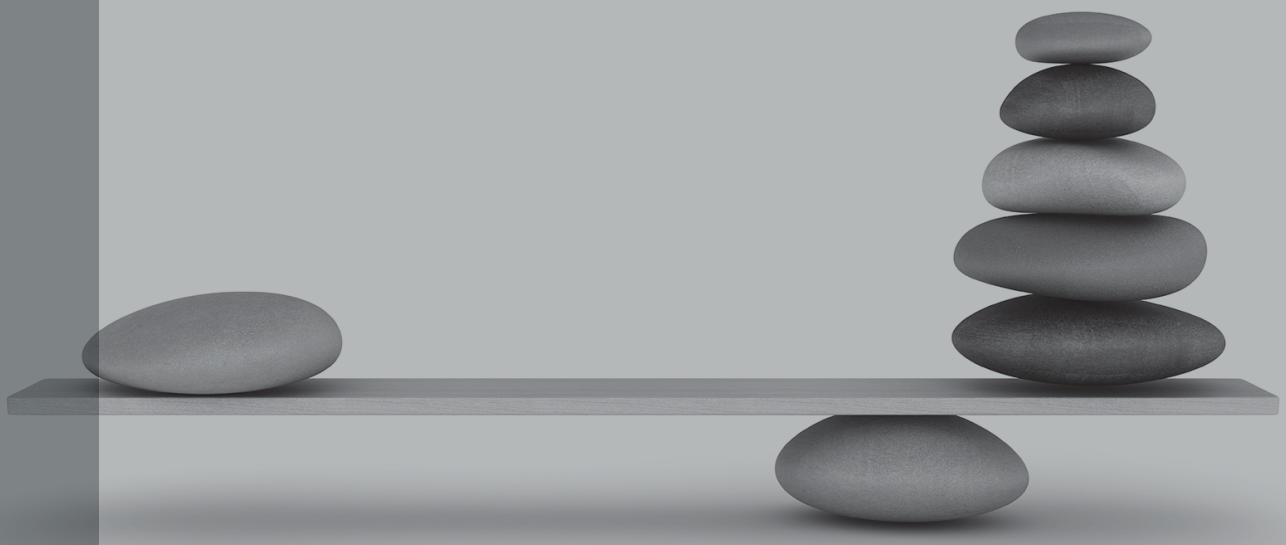
Equity, Values, and Health Decisions in Ontario

A Converge3 Methods Report



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About Converge3
Converge3 is a policy research centre based in the Institute of Health Policy, Management and Evaluation at the University of Toronto that focuses on integrating health, economic and equity evidence to inform policy. The Centre is funded by the Province of Ontario and includes multiple partner organizations, including Li Ka Shing Knowledge Institute at St. Michael's Hospital, McMaster University, Ottawa Hospital Research Institute, ICES, Health Quality Ontario, Public Health Ontario, and the Ontario Ministry of Health.

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Abstract

Decision makers within health contexts are often asked to consider equity alongside other considerations, particularly when making resource allocation decisions. However, a clear conceptualization of equity is often missing. Furthermore, approaches to equity may vary as governments change. In this report, we explore the ethical basis that underlies different approaches to defining equity and argue that understanding such approaches is useful for decision makers who are seeking to evaluate and measure the equity implications of decisions. We also explore how such approaches can serve as the basis for value frameworks, which are being more frequently promoted as a way to structure thinking around resource allocation decision making. A deontological ethics approach asserts that the value of an act comes from its moral nature. Hence, equity is viewed through the perspective of duties and rights, such as the right to health. A consequentialist ethics approach asserts that the value of an act is judged by the outcomes that it produces. Utilitarianism is a form of consequentialist ethics that underlies many forms of economic evaluation. Utilitarianism typically focuses on efficiency (maximizing health within a budget constraint) but rarely incorporates equity concerns. Virtue ethics stress traits that are socially valuable without necessarily having moral value. The main limitation of such approaches is the contextual nature of decision making. Capability theory and communitarian approaches are both closely linked with virtue ethics and support the idea of developing value frameworks and incorporating deliberative dialogue into decision making. Three Ontario health equity frameworks (Public Health Ontario's equity framework, the Ministry of Health and Long-term Cares' Health Equity Impact Assessment tool, and the Ontario Health Technology Advisory Committee Ontario Decision Framework) are reviewed and found to be most compatible with virtue ethics approaches, focusing on addressing inequities in access or in health outcomes. For such approaches to progress in Ontario, value frameworks need to be explicit, inclusive in their development, clear about the necessity for trade-offs and how to consider relative values, and thoughtful in how they integrate such frameworks with deliberation.

Introduction

Resource allocation decisions in health are challenging. Governments and the public are interested in making sure that funds are used efficiently – that is, that the greatest possible benefits are obtained for a given expenditure. But efficiency is never the sole concern for either decision makers or the public.[1,2] For example, concerns for specific populations – such as individuals with rare and life-threatening diseases – may prompt governments to allocate resources to those populations, even if that allocation may have yielded greater health benefits if the funds were spent, say, on individuals with a more common and less severe illness. In this way, efficiency can be considered an attribute that is valued by decision makers, but it is almost never the sole value.[3] To the extent that other values address issues of fairness and justice, they can be considered as components of equity. In philosophical terms, however, concepts such as fairness and justice are considered "essentially contested" – that is, there will never be a universal consensus on what these terms mean and, further, it is not possible to fashion a syncretic solution by borrowing from multiple perspectives.[4]

Considering equity as an essentially contested concept does not mean, however, that equity cannot be defined or measured. Instead, it implies that various definitions may sometimes be in conflict. Accordingly, equity is not the domain of one ideological perspective but, rather, is intrinsically tied to values.[5] A specific government's view of what constitutes equity may differ from its predecessors depending on what values are shared and which are different. In pluralistic societies, no single value structure is viewed as normative, although some values prevail, perhaps for some time. Even values for which there seems to be a consensus may be only superficially universal – we may say that we value life over death, for example, but some individuals, in some circumstances, value death over life, as exemplified by the debate over medical assistance in dying in Canada.[6] The legal resolution of this debate should not obscure the irreconcilable value conflict between those for and against this policy. Note that throughout this document, we are concerned with value conflicts between individuals (rather than within an individual) and with values that are shared across individuals within groups.[7]

Considering equity as an expression of values has three important implications. First, not only do values differ but so, also, do value systems, by which we mean the organizing structures by which values are defined.[5,8] Understanding such value systems can help to understand how values are constructed – for example, whether values are universal or situational. Second, considering equity within a value framework can be helpful for considering whether competing equity claims can be reconciled and how this could be done. Third, considering equity within a values framework also clarifies thinking about how equity is measured. While these are complex issues with multiple dimensions, our discussion is focused on exploring how addressing such issues can aid the practical application of equity considerations into health resource allocation decisions.

Three value systems

When we speak of values, we imply that there is a ranking (which may be implicit or explicit) of some thing over some other thing. Before we can address the question of how the ranking is done, we first ask how the equity "things" are selected. We consider three values systems – ethical frameworks that determine what gets valued.[5] We recognize that decision makers rarely have well-articulated frameworks and may draw from different frameworks for different decisions or at distinct times. Nevertheless, this approach is beneficial for thinking about the implicit frameworks in policy making and in research. Although there are more value systems than just these three, we believe these are the most important frameworks for understanding equity in health.

Deontological ethics

In deontological ethical systems, values are drawn from a set of moral rules and a method for determining what to do when rules come into conflict.[9] The value of an act is drawn from consideration of the moral nature and permissibility of actions. As such, the goal of a

deontological approach is to encourage individuals to do what is morally right. For example, Kantian ethics holds that the moral worth of an action should be grounded in reason and based on morality (and not on the consequences) of an action. One way to judge if an action is moral is to consider what would happen if it was universally adopted; thus, fraud is morally impermissible because a society rife with fraud is one that we would each want to avoid.[8] Deontological ethics also strongly rejects using individuals as means to an end. Rather, each individual is due equal respect. Such thinking underlies rights-based approaches, which similarly stress the legitimate claims that individuals can make on society. Individuals have both positive (access to) and negative (freedom from) rights for which they may in turn have subsequent duties or obligations. Critics of deontological frameworks see them as overly rigid and point out that balancing competing claims or rights can be challenging within a deontological framework.[10]

A deontological approach might assert that health is essential to human dignity. Therefore, the best society is one where everyone is healthy and encouraging health is a moral duty. Some might extend this farther to say that there is a universal and fundamental right to health.[11] Value frameworks that are based on classic deontological frameworks would therefore be hierarchical in nature, in the sense that some considerations clearly trump others because they have a greater moral claim to be right.

Much of the literature on equity in health implicitly adopts a deontological framework. Consider, for example, Margaret Whitehead's well-known definition of health equity as "differences in health that are unnecessary, avoidable, unfair and unjust."[12] Intrinsically linking concepts of equity to those of fairness and justice underscores the connection to doing what is morally right. Literature that conceptualizes health as social justice or health as a human right is similarly situating health equity within this framework.[5]

A deontological approach can be very useful for making equity arguments for addressing inequalities or disparities in health, particularly when groups have equal claims to health. In Ontario, for example, policy makers may be concerned that an individual with an acute myocardial infarction might have less access to immediate life-saving interventions in a rural setting than in an urban setting. Such approaches may be less straightforward, however, when there are competing duty-based or rights-based arguments. Consider, for example, the current debate about decriminalization of illegal drug possession for personal use in Canada.[13] A deontological argument in favour of decriminalization might argue that people who use illegal drugs have a right to health and that laws that impede this right are therefore unfair and have a negative impact on equity. A deontological argument against decriminalization might argue that having barriers to accessing drugs that are currently illegal is a morally right thing to do because of the potential harms associated with universal access. The resolution of such competing claims is often challenging; indeed, some claims may not be capable of being resolved. Rather, one claim may win over another in the courts or because it is championed by the government of the day. For resource allocation decisions in particular, deontological approaches may be useful for defining the bounds of such decisions (what is outside the boundary of acceptable), but may be challenging to use for day-to-day decisions, which are more about trade-offs and less about one perspective prevailing over another.

Consequentialist and utilitarian ethics

Consequentialist ethics specify things that are good in themselves and promote policies that maximize these things.[14] Thus, an act is considered right or wrong based on the results of the act rather than on the inherent duty to perform that act. Furthermore, acts that produce greater net good consequences are the most preferred. Act consequentialism focuses on the expected outcomes of specific actions and would be exemplified in health research, for example, by modeling or forecasting studies. Rule consequentialism focuses less on specific acts but rather on the typical consequences of actions – thus fraud is wrong because, in the long run, it leads to negative consequences,

even though some may benefit considerably from individual acts of fraud.[15] Utilitarianism is a form of consequentialism that holds that the most morally permissible action is one that will produce the most utility (happiness) for society as a whole.[16] Classic utilitarianism is not concerned with the distribution of this utility but only with the aggregate amount of utility gained.[17,18]

Consequentialism as applied to health assumes that the goal of health policies is to achieve some objective function, such as survival, quality-adjusted survival, or another measure of well-being. Utilitarianism applied to health makes two additional assumptions. First, utilitarianism assumes that utility in health can be measured and quantified. Note that in almost all other domains, utility is assumed to have ordinal qualities (it is possible to say which goods are preferred over other goods) but not cardinal qualities. Within health care, the quality-adjusted life year (QALY) has been promoted as a measure of utility although empirical studies have shown that it fails to meet several of the requirements of a true utility measure.[19,20] Others have argued that a QALY can still be used with the recognition that the objective of obtaining as many QALYs as possible is health maximization (which is still a consequentialist goal) rather than utility maximization.[21] The second assumption is that all gains are valued equally. Thus, utilitarianism is indifferent between the situations where QALYs are gained by a historically privileged or a historically disadvantaged group.

Economic evaluations that use cost-effectiveness or cost-benefit analyses are inherently utilitarian in their approach. In addition to the assumptions specified above, economic evaluations are also indifferent to the distribution of benefits; thus, a net gain of 100 QALYs is viewed similarly if 100 people are gaining, on average, 1 QALY each or if 10 people are gaining, on average, 10 QALYs each. Many authors have proposed extensions to cost-effectiveness analysis to address such concerns, including distributional cost-effectiveness analysis.[22,23] These extensions generally move decision making away from a purely utilitarian framework (although they may still be consequentialist if they focus on maximizing an objective function, albeit one that now incorporates concerns beyond individual utility).[17]

While consequentialist approaches have been applied widely in health resource allocation decisions, they have largely been criticized as neglecting equity concerns.[18] An argument in defense of consequentialist approaches that appeals to the original concept of utility would argue that only individuals can truly assess their own happiness. Thus, the most equitable society is that which allows individuals the scope to maximize their utility without being encumbered by excessive taxation or regulation. Such arguments might underlie, for example, a libertarian approach to the question of decriminalization of illegal drug possession raised above. A more conventional health economics approach would quantify the benefits and harms of decriminalization with a conclusion based solely on which approach maximizes health and without considering rights or community values. Some have defended utilitarianism, in the form of QALY maximization, as the main approach to resource allocation for global health, arguing that health maximization is the primary goal of most health polices and that utilitarianism provides the best basis for making difficult trade-off decisions.[16] To the extent that good health is a requirement for maximizing individual utility, QALY maximization can also be seen as a form of act utilitarianism (in practice, however, many individuals seem to choose to forego some QALYS by eating unhealthy diets or drinking alcohol. To the extent that these are rational decisions, their utility functions seem to be maximized by focusing on other objectives).

Virtue ethics, capability, and communitarian approaches

Virtue ethics based approaches stress traits that are socially valuable – such as generosity and kindness – without, necessarily, having moral value.[14] An act is considered right if a virtuous person would act that way in the same circumstance. Virtue ethics is thus less concerned with duties, rules, and consequences. Deciding what a virtuous person would do comes from a consideration of emotions, intuitions, motivations, and reasoning. Virtue ethics is therefore both contextual and pragmatic.[8] Critics of virtue ethics

stress that there is no assurance that good results will come from good intentions; furthermore, the lack of universal standards makes it difficult to develop standards that apply across contexts. Capability theory is a philosophical approach that is grounded in virtue ethics.[24,25] Capabilities are defined as "the opportunity to achieve valuable combinations of human functionings – what a person is able to do or be."[26] Capability approaches stress both ability to do actions and having the necessary "means, instruments, or permissions" to do these actions. Some capability lists include items such as bodily health and bodily integrity.[27,28] These are seen as necessary for achieving capability but are not conceptualized as individual rights. Communitarian approaches apply virtue-based approaches within communities to make decisions through finding shared values.[7,29] This is often a trial-and-error process with trust that the process will yield optimal results.

Much of health research draws from capability or communitarian based approaches, although often implicitly. For example, social determinants of health can be viewed as one set of capabilities although, typically, capabilities would be viewed as broader than this list. As in the capabilities literature, however, the social determinants of health are rarely viewed as individual rights but rather as potential policy levers on which to intervene to achieve higher goals.[30] Similarly, studies of barriers and facilitators to care, such as the Andersen framework, and some health policy analyses can be viewed as research into the necessary facilitators to achieve capability.[31] Communitarian approaches are reflected in agencies such as citizen's councils and in the inclusion of patient representatives in deliberative dialogues for decision making, such as in national and provincial drug formulary advisory committees.[32]

Much of the health economics literature on health equity has adopted approaches that build from communitarian and virtue ethics based approaches. For example, there has recently been considerable interest among many professional bodies, including some focused on health economics, in defining "values frameworks."[33] Typically, organizations gather together panels of experts who deliberate on which values are integral to decision making in their field. Equity is variably included in some frameworks and, when it is, it may be viewed as a single value or decomposed into constituent elements of equity (we explore value frameworks further below).[33] The incorporation of patient and the public representatives in decision making bodies, reflects a communitarian commitment to exploring shared values around equity and a recognition that doing so requires a broader inclusion of voices than just scientific experts alone.[32]

The strengths and limitations of virtue ethics approaches lie in their contextual nature. Deliberation, in particular, is well suited to resolving competing equity claims although there is no assurance that the decision for one time and place will be appropriate in other contexts. Evidence indicates that careful, deliberate consideration and discussion of the advantages and disadvantages of various options may lead to better understanding of problems, consensus building, identification of evidence gaps, increased buy-in, identification of important selection biases among discussants, and greater contextualization of decisions.[34] However, deliberations may be dominated by prominent voices and may be prone to cognitive biases (for example, participants may be prone to confirmation bias, in which they become entrenched in their views with more deliberation rather than more open to conflicting evidence).[34] Deliberations may need to be well structured to be optimally effective.[34]

Consider again the question of decriminalization of illegal drug possession. A communitarian approach would seek an answer that is the best solution within a defined region at a specific time, but the solution selected by a community in a developed urban setting, like downtown Toronto, may be very different than that selected by a community in a suburban context, like Markham. Value frameworks, in contrast, have not yet rigorously addressed how to address competing values. Few value frameworks have quantitatively defined the weights that are to be applied to various components of the value framework, although some researchers have tried to define these.[33]

Equity of what?

So far, we have considered how equity is conceptualized within value frameworks (as a right or duty in deontological frameworks, as a component of individual happiness in utilitarian frameworks, or as one of several objectives to be considered simultaneously in virtue ethics frameworks). As important, however, is a consideration of what should be equal. To put this another way, equity implies both fairness and equality.[35,36] We have discussed ethical approaches to defining fairness but have not specified what is being fairly distributed. A recent systematic review of equity considerations in health noted that there were a wide range of definitions, including "access to health care and health outcomes equal between populations," "fairness in the distribution of resources enabling people to achieve … health … and reducing health disparities," "highest possible standard of health for all people," "equal opportunity for access for those at equal risk", "equal access for equal need," and "equitable health care rather than … outcomes."[37]

We consider four possible perspectives and the corresponding objectives in more detail below. We also consider how these objectives integrate with the value frameworks noted above (we list only one perspective but recognize that others are possible and that, in general, we have simplified debates that ethicists and philosophers have had within these objectives). As a heuristic device, we ask how each perspective would answer the question, "Why do we care about the health of strangers?" We also explore how each perspective would address the question of how to measure inequity in a way that facilitates policy objectives.

Equity in individual freedom

A first perspective is grounded in classic liberalism and a utilitarian perspective. It would assert that the goal of society is to allow each individual to maximize their own utility, or happiness, with as few encumbrances as possible. Thus, equity is defined as the freedom to pursue those activities that would maximize utility. The fairest society is, accordingly, that which restricts people the least. Adherents of this perspective would assert that we do not actually care about the health of strangers; rather, we care about the ability of strangers to maximize their utility, which may or may not include maximizing health. This perspective may be reflected, for example, in policy decisions such as the legalization of marijuana or increased availability of beer in Ontario (marijuana legalization could also be argued from a consequentialist perspective, given the balance of risks and harms). Measuring inequity from this perspective is virtually impossible since individual utility is subjective.

Equity in the opportunity to access care

A second perspective focuses on the opportunity to access health care. The goal, from this perspective, is to remove barriers that are seen to be unfair or unjust while recognizing that individuals still have freedom and choices that will determine their ultimate health. This perspective would fit well into a deontological perspective that asserts that we have a duty to ensure access to care or that individuals have a right to health care (although not necessarily a right to health). Thus, we care about the health of strangers because health care is a right for all and ensuring access to care is a collective duty in a just society. A capability framework would similarly argue that health is essential to human dignity and therefore, policies that increase health should be endorsed. This perspective may be reflected, for example, in policy decisions such as the discussion in Canada regarding the expansion of universal health insurance to include prescription drugs, known as pharmacare (indeed, some of the arguments against pharmacare are based in consequentialist arguments that the current system is working reasonably well and any health gains are likely to be small). Measuring equity from this perspective is relatively straightforward, focusing on insurance coverage and similar measures. The goal of coverage is typically universal or near universal coverage, especially when objectives are framed as rights.

Equity in access to services and care

A third perspective focuses not on the opportunity to access care but on empirically measured use

of health services. Economists have referred to such concerns as "horizontal equity," the idea that individuals with similar needs should have similar access to care. Typically, the focus of such perspectives is on disparities to care across geographic regions or across social groups defined by characteristics such as ethnicity or income level. As discussed above, this perspective is sometimes viewed within a deontological or rights framework but more frequently within a capabilities framework, where the factors that impede access are seen as unjustified barriers to achieving full health. Thus, there may not be a right to be free from poverty or to have geographic access to emergency health services but the lack of such services is an equity policy problem nevertheless. This perspective would argue that we care about the health of strangers because we share the goal of a healthy society, which requires having healthy people. This perspective may be reflected, for example, in the dedicated funding for Indigenous health services. Measurement requires definition of both the populations in whom access will be measured and the outcome measures. Equity itself can be multi-dimensional (see Value Frameworks, below).

Equity in health outcomes

A fourth perspective focuses on equality of health outcomes themselves. In practice, equality of health may be possible for limited or highly focused goals but is an impractical objective for health policy as a whole. Accordingly, adherents of this perspective have instead focused on prioritizing individuals who are in poor health as a means of decreasing disparities in health. Economists have referred to such perspectives as "vertical equity." An alternative approach is to focus on threshold levels of health as a policy objective although in practice, these seem to focus more on health services – ensuring high levels of childhood immunization, for example – than health attainment. Such approaches are consistent with a virtue ethics approach, particularly if health disparities themselves are viewed as a negative consequence for future health and well-being. Measurement within health economic evaluation would typically focus on minimizing differences in QALYs – either gains in QALYs or final QALY attainment. Measurement outside of health research is more complex since universal health measures are not consistently used to evaluate health programs.

Value frameworks

We focus next on value frameworks, noting that the adoption of a value framework approach implies certain ethical choices. Nevertheless, as noted above, several academic publications and clinical societies have moved towards developing value frameworks and these may be attractive to public decision makers in the future. Value frameworks typically take the form of checklists or diagrams.[33,38-40] Some elements that are commonly included in frameworks include considerations of survival and quality of life. Specific factors that may be important for equity considerations include the distribution of harms, the distribution of benefits, the size of the population who benefits, whether interventions are health improving or preventative, whether (public health) interventions are universal or delivered to a targeted group, whether there are additional benefits to individuals beyond those receiving the intervention, and whether there are non-health benefits alongside those related to health. Additional equity criteria might relate to "social" rather than "health" equity, by which we mean non-health disparities in domains between groups, such as historical marginalization, discrimination, or equity. While there may be a correlation between social and health equity factors, this association is not universal. Decision makers will need to decide whether addressing social inequity through investments in health, rather than other sectors, is an optimal use of resources. This list should be viewed as illustrative, rather than as exhaustive, of equity-related criteria. Note that we have not listed the rather long set of criteria that are not related to equity. We also have also not ranked or weighted these criteria. Thus, value frameworks require considerable development. Furthermore, decision makers will need to consider how value frameworks are used alongside deliberative processes.

Three ontario approaches

We briefly review three Ontario approaches to health equity.

Public Health Ontario

Public Health Ontario has a goal to address social inequities and explicitly recognizes that health is key to overall well-being.[41] The agency states that:

> Health equity is created when individuals have the fair opportunity to reach their fullest health potential. Achieving health equity requires reducing unnecessary and avoidable differences that are unfair and unjust.

The Ontario Public Health Standards mandate the identification of priority populations by Boards of Health in order to deliver public health programs and services to meet the needs of their communities. Priority populations are identified by

> considering those with health inequities including: increased burden of illness; or increased risk for adverse health outcome(s); and/or those who may experience barriers in accessing public health or other health services or who would benefit from public health action

Public Health Ontario's approach to addressing health equity is based in "proportionate universalism," which states that "people across the whole population gradient are entitled to social benefits proportionate to their needs" and "encompasses both targeted and universal approaches to ensure the population as a whole is proportionately allocated benefits and services."

Public Health Ontario's approach is consistent with a capability approach, using similar language ("the fair opportunity to reach their fullest health potential") and focusing on access to public health services, with a broad consideration of health and social factors that should be addressed to achieve equity. Proportionate universalism is at last partially consistent with the concept of vertical equity, in that benefits are allocated in proportion to need.

Ontario health equity impact assessment

The Ontario Ministry of Health and Long-Term Care has developed a Health Equity Impact Assessment tool to help organizations evaluate how a "program, policy or similar initiative will impact population groups in different ways."[42] The tool includes a template and a workbook that identifies key populations and guides users through identifying positive and negative impacts, mitigation and mentoring strategies, and dissemination. The tool is focused on the identification of unintended positive and negative impacts, rather than on the intended benefits of the initiative.

The workbook defines equity as "reducing systemic barriers in access to high equity health care for all by addressing the specific health needs of people along the social gradient, including the most health-disadvantaged populations."[42] The tool further defines health inequities as "differences in health outcomes that are avoidable, unfair, and systemically related to social inequality and marginalization."[42] While the tool is customizable, the template comes with a pre-populated list of the following populations and characteristics of individuals that "may experience significant unintended health impacts": Aboriginal peoples, age-related groups, disability, ethno-racial communities, Francophones, homeless, linguistic communities, low income, religious / faith communities, rural / remote or inner-urban populations, sex / gender, and sexual orientation.[42]

As with the Public Health Ontario approach, the Ontario Health Equity Impact Assessment tool uses a definition of equity that is focused on access to care for defined populations. In contrast to other approaches, the tool has a somewhat narrow focus on the unintended equity consequences of a decision. The approach to mitigation outlined in the workbook include strategies that could be considered within the communitarian framework by including members of priority groups.

The Ontario health technology advisory committee Ontario decision framework

The Ontario Health Technology Advisory Committee has published a decision framework to guide decision making around nondrug health technologies. The framework includes three broad categories of attributes: 1) context criteria, including factors such as stakeholders, adoption pressures from neighbouring jurisdictions, and potential conflicts of interest; 2) primary appraisal criteria attributes including benefits and harms, economics, and patient-centered care; and 3) feasibility criteria including budget impact and organizational feasibility.[39] The framework is explicitly rooted in a theoretical approach focused on optimal decision making, rather than health or welfare maximization.

The Ontario Decision Framework is explicitly focused on values:

> [Health Technology Assessment] agencies often refer to broad ethical principles which serve as the foundation of their decision making. For example, autonomy, nonmaleficence, beneficence, and distributive justice have been cited as key ethical principles that underlie social value judgments … identifying a broader set of fundamental social values makes it possible to be more explicit about how practical work is linked to values.[39]

Equity is considered within the framework as part of Patient-Centred Care alongside additional values of solidarity, population health, collaboration, and shared responsibility for health. The worksheet identifies equity as "enhances equity in access or outcomes" and prompts users by asking "Are there disadvantaged populations or populations in need whose access to care or health outcomes might be improved (or not worsened) that are relevant to this assessment?"[39]

The Ontario Decision Framework is the only one of the three Ontario frameworks to include equity of outcomes as a consideration alongside equity of access. The framework also identifies "need" (presumably a need for health improvement) as a target for equity. The establishment of an explicit values framework is most consistent with a virtue ethics approach to consideration of health equity.

Discussion

The approach to consideration of health equity used in this report starts by asserting that equity is not the domain of any single ideology or political party. Rather than ask who is the champion of equity, we have assumed that a commitment to equity is universal as far as equity is described in terms of fairness and equality; the key differences lie in what is considered fair and in what should be distributed equally (or less unequally). Our use of ethical frameworks both grounds our discussion in theoretical bases and highlights how some disagreements about equity are not reconcilable.

Value frameworks are most closely aligned with a virtue ethics based approach to resource allocation within health. It is notable that three established Ontario frameworks are each aligned with this approach, although in somewhat different ways. Utilitarian and consequentialist approaches are likely to remain essential for informing decision making, such as the basis for economic evaluation, but appear inadequate as the sole basis for decision making in most jurisdictions. Deontological approaches occasionally arise in policy discussions (claims like "everybody has a right to health" or "anything that promotes drug use is wrong") but are not strongly reflected in the Ontario frameworks. This may reflect an aversion to including rigid statements in these frameworks or, more pragmatically, may reflect that the audience for these frameworks are decision makers who have to weigh multiple considerations. Strong statements regarding duties and morals are the domain of politicians and activists, rather than directors and managers.

Value frameworks and deliberation are at the core of communitarian and virtue ethic based approaches. The use of such approaches seems to be increasing in Ontario and globally. However, further integration of these approaches into decision making has several implications. First, value frameworks likely work best when the

values underlying a decision are explicit. Second, the process of defining those values is optimal when it is broadly inclusive and reflective of community values. In the absence of an explicit Ontario health value framework, listing the relevant values, perhaps against published checklists, may aid decision makers. Third, the use of a value framework approach implies the rejection of a deontological approach. In practical terms, no single value or set of values trumps any other. Fourth, most value frameworks do not have specific weights attached to values; however, the implicit assumption that all values are equally important is unlikely to be true. Fifth, deliberation will be essential to consider how to address competing values and how to further contextualize decisions.

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