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A Strategy to Improve Priority Setting in Health Care Institutions

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Priority setting (also known as resource allocation or rationing) occurs at every level of every health system and is one of the most significant health care policy questions of the 21st century. Because it is so prevalent and context specific, improving priority setting in a health system entails improving it in the institutions that constitute the system. But, how should this be done? Normative approaches are necessary because they help identify key values that clarify policy choices, but insufficient because different approaches lead to different conclusions and there is no consensus about which ones are correct, and they are too abstract to be directly used in actual decision making. Empirical approaches are necessary because they help to identify what is being done and what can be done, but are insufficient because they cannot identify what should be done. Moreover, to be really helpful, an improvement strategy must utilize rigorous research methods that are able to analyze and capture experience so that past problems are corrected and lessons can be shared with others. Therefore, a constructive, practical and accessible improvement strategy must be research-based and combine both normative and empirical methods. In this paper we propose a research-based improvement strategy that involves combining three linked methods: case study research to describe priority setting; interdisciplinary research to evaluate the description using an ethical framework; and action research to improve priority setting. This

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describe-evaluate-improve strategy is a generalizable method that can be used in different health care institutions to improve priority setting in that context.

KEY WORDS: empirical bioethics; fairness; improvement; interdisciplinary research; priority setting; resource allocation.

INTRODUCTION

Imagine you are the CEO of a hospital (or Regional Health Authority, or Disease Management Organization, or Pharmaceutical Benefit Management Organization, or Managed Care Organization, or Public Health Unit, or Clinical Program). Decisions are constantly being made in your organization about how to spend the organization's money. The amount of money available to spend is never adequate to pay for everything you wish you could spend it on, therefore you must set spending priorities. There are two questions you need to be able to answer for the sustainability of the organization and for your own job security: How should we set priorities in this organization? How do we know when we are doing it well? This paper will suggest answers to these vital questions.

An answer that one might expect from a traditional bioethics approach might sound like this: Memorize and apply the three primary philosophical principles of bioethics (*autonomy, beneficence, justice*). Get a trained bioethicist to critique your decisions. Add other principles if deemed necessary.

However, the key to unlocking real-world answers is an approach that is more constructive, interdisciplinary, practical and accessible to decision makers. Normative approaches (such as the principlist one mentioned above) are necessary because they help identify key values that clarify policy choices, but insufficient because different principles (or, more generally, theories) lead to different conclusions and there is no consensus about which ones are correct, and they are too abstract to be directly used in actual decision making. Empirical approaches are necessary because they help to identify what is being done and what can be done, but are insufficient because they cannot identify what should be done. Moreover, to be really helpful, an improvement strategy must utilize rigorous research methods that are able to analyze and capture experience so that past problems are corrected and lessons can be shared with others. Therefore, a constructive, interdisciplinary, practical and accessible improvement strategy must be research-based and combine both normative and empirical methods.

We recently reviewed the current state of priority setting knowledge and proposed a new research approach that is based on four arguments (Martin & Singer, 2000). First, traditional discipline-specific approaches to priority setting (e.g. from philosophy, law, political science, medicine, and health economics) are insufficient because they are not grounded in actual experiences of priority setting in health care institutions, and the values that they contribute to priority setting conflict. Second, the current state of priority setting approaches can be conceptualized as a set of dialectical opposites: substantive criteria (e.g. efficiency,

equity) can be contrasted with process criteria; and "simple solutions" (Holm, 1998) (e.g. CEA) can be contrasted with "muddling through" (Klein, 1998), an experimental and incremental policy making process. Third, what is now needed is a synthesis that integrates these dialectical opposites into an ethical framework incorporating both substantive and process criteria, and encompassing both "simple solutions" and "muddling through." Fourth, a research strategy to achieve this synthesis will include a combination of empirical description using case studies and interdisciplinary evaluation using the best process-focused ethical framework.

Ham and Coulter (2001) summarized international experience with health care priority setting, and concluded: there is a need to strengthen institutional processes in which decisions are taken; priority setting processes must be transparent and accountable; clinical guidelines are increasingly being used as a priority setting tool, but fair processes are needed for guidelines, just as for priority setting more generally; the politics of rationing favours muddling through and the evasion of responsibility, but this is unsustainable in an era of increasing public awareness about policy making; priority setting policy making is an exercise in policy learning; and "accountability for reasonableness" is a leading ethical framework for priority setting in institutions. Accordingly, a strategy for improving priority setting in health care institutions entails improving priority setting processes using the guidance provided by "accountability for reasonableness."

The strategy we propose involves combining three linked methods: case study research to *describe* priority setting; interdisciplinary research to *evaluate* the description using an ethical framework; and action research to *improve* priority setting. This *describe-evaluate-improve* strategy is a generalizable method that can be used in different institutions or organizations to improve priority setting in that context.

In this paper we will describe the need for an empirical foundation, describe an ethical framework for priority setting in health care institutions, and provide a detailed proposal of a research-based improvement strategy.

THE NEED FOR AN EMPIRICAL FOUNDATION

Priority setting (also known as rationing or resource allocation) can be defined as the distribution of resources among competing programs or people (McKneally, et al., 1997). A common problem in every country in the world, priority setting is faced in both primarily publicly funded systems, such as Canada or the UK, and also in primarily privately funded systems such as the US, and in both developed and developing countries. It occurs simultaneously at the *macro* (health system), *meso* (institution), and *micro* (bedside) policy making levels. While, most priority setting research has focussed on the *macro* or *micro* levels, little research has focussed on the *meso* level where much of the priority setting action within a health system actually occurs. For example, hospitals alone account for one-third of Canada's public spending on health care (Canadian Institute). There are several

analyses of the problem of priority setting in regional health authorities (RHAs) (see Williams and Yeo, 2000; Williams et al., 1996; Hurley et al., 1995; Bear et al., 1998; Ham, 1993) as well as in hospitals (see Singer and Mapa, 1998; Kovac, 1998; Taylor et al., 1998; Blundell and Windmeijer, 2000; Eland et al., 1998; Alexander et al., 1998). However, none of these used empirical methods to examine actual priority setting. To our knowledge, only a few studies have used empirical methods to examine actual priority setting in an institution. Foy et al. (1999) found that priority setting decisions regarding new cancer drugs in a cancer hospital and a consortium of six RHAs were based on "evidence thresholds"—cut-off points determined from information on effectiveness. Hope et al. (1998) described the use of evidence of effectiveness, equity, and patient choice in a RHA's priority setting decisions. Deber et al. (1994) described technology acquisition in Canadian hospitals. However, these studies focused narrowly on new technologies or select cases, not on the entire range of priority setting decisions.

There is little research on how decision making bodies deliberate upon and make actual priority setting decisions. Knowledge of actual practices is crucial to advance understanding of priority setting. There is an increasing demand for evidence-based policy making (Black and Donald, 2001; Ham et al., 1995). As Kleinman (1999, p. 6) notes, knowledge regarding complex social pheonomena must be grounded in "local worlds."

> Local worlds are, among other things, also the grounds of social experiences of health, suffering, and health care. What is at stake for patients, family members, and professional health care providers in particular localities defines one side of health rights and responsibilities: we might call this side . . . moral processes. These same moral processes incarnate the inequities in health status and in the distribution of health care resources that is the source of concerns about health equity and social justice.

Any model of priority setting that is not empirically grounded may not make sense to those it concerns, and consequently interventions generated from such a model may be impractical. For example, the lack of an empirically grounded model may make it more difficult for different groups (or even the same group) of priority setting decision makers to make consistent decisions. However, knowing how groups make decisions does not tell us what decisions they should make.

THE NEED FOR AN ETHICAL FRAMEWORK FOR PRIORITY SETTING IN HEALTH CARE INSTITUTIONS

Knowing what priority setting decisions to make would be quite simple if we could agree on priority setting principles to guide deliberations. However, international experience has shown the difficulty in reaching agreement on *what* priority setting decisions should be made (Ham and Coulter, 2001; Daniels and Sabin, 2002). Philosophical theories of justice (e.g., utilitarianism, egalitarianism, communitarianism) lead to different outcomes and there is no agreement about which theory is correct. Economic approaches (e.g., cost-effectiveness analysis) are helpful, but are practically limited and emphasize values (e.g., efficiency) about

Table I. The Four Conditions of "Accountability for Reasonableness"

Relevance	Rationales for priority setting decisions must rest on reasons (evidence and principles) that "fair-minded" people can agree are relevant in the context. "Fair-minded" people seek to cooperate according to terms they can justify to each other—this narrows, though does not eliminate, the scope of controversy, which is further narrowed by specifying that reasons must be relevant to the specific priority setting context.
Publicity	Priority setting decisions and their rationales must be publicly accessible—justice cannot abide secrets where people's well being is concerned.
Appeals	There must be a mechanism for challenge, including the opportunity for revising decisions in light of considerations that stakeholders may raise.
Enforcement	There is either voluntary or public regulation of the process to ensure that the first three conditions are met.

which there is no consensus. Legal approaches tell us what is unacceptable (e.g., discrimination) not what is right. Organizational ethics approaches tell us that organizational decision making should reflect organizational values, but not how to achieve that goal.

Since we cannot reach agreement on *what* priority setting decisions should be made, we must seek agreement on *how* they should be made—that is, we should focus not on getting the "right" priority setting outcomes, but on using a "good" priority setting process. But what do we mean by "good"? When focussing on process, "good" means "fair." But what do we mean by "fair"? "Accountability for reasonableness" is an ethical framework for fair priority setting (Daniels, 2000; Daniels and Sabin, 2002).

"Accountability for reasonableness" was developed in the context of U.S. Health Maintenance Organizations (Daniels and Sabin, 1997), and has been used to study actual priority setting processes (see Ham, 1999; Ham and McIver, 2000; Norheim, 2000), and so is relevant to real-world priority setting. It is theoretically grounded in justice theories emphasizing democratic deliberation (Cohen, 1994; Rawls, 1993).

According to "accountability for reasonableness," an institution's priority setting process is fair to the degree it meets four conditions (described in Table I): *relevance*, *publicity*, *appeals*, and *enforcement*.

"Accountability for reasonableness" is the leading ethical framework for priority setting in health care institutions because it is the only approach that is empirically based, ethically justified, and focused on process. It can be used as an analytic lens to facilitate social learning about priority setting. It connects priority setting to broader, more fundamental democratic deliberative processes that have an impact on social justice.

A RESEARCH-BASED IMPROVEMENT STRATEGY

Our research-based improvement strategy involves empirical research in bioethics that combines three linked methods: case study research to *describe*

priority setting; interdisciplinary research to *evaluate* the description against "accountability for reasonableness"; and action research to *improve* priority setting in context. This strategy is innovative because there are only a few limited description of actual priority setting in health care institutions, priority setting in health care institutions has not been evaluated using "accountability for reasonableness," and there have been no efforts to improve priority setting using action research.

Phase I: Describe

A necessary first step involves *describing* actual priority setting in context (e.g., in a hospital) using case study methods. A case study is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context" (Yin, 1994). This is the appropriate method because priority setting in health care institutions is complex, context-dependent, and involves social processes. Case study methods provide a structured yet flexible approach to data collection and analysis.

We used case study methods to describe priority setting for new technologies in cancer and cardiac care by priority setting committees in two provincial disease-management organizations (Singer et al., 2000). Our findings included six interrelated domains for priority setting for new technologies in medicine: the institutions in which the decision are made, the people who make the decisions, the factors they consider, the reasons for the decisions, the process of decision making, and the appeals mechanism for challenging the decisions. These six domains constitute an empirically-based model of priority setting for new technologies in medicine.

Again using case study methods, we also described the rationales used by a committee setting priorities for new cancer drugs—specifically, we described the decisions and rationales related to 14 new drugs in eight disease conditions over three years (Martin et al., 2001). Our key finding was that using empirical methods to observe priority-setting decisions and their rationales in actual practice revealed lessons not contained in theoretical accounts. Some of the previously undescribed lessons included: priority setting operated in relation to resource mobilization; in the context of an expanding budget, rationales changed; as costs for individual treatments increased, rationales changed; and priority setting rationales involve clusters of factors, not simple trade-offs.

Phase II: Evaluate

Next, because what decision makers do may not be what they should do, a second step is to *evaluate* these processes with interdisciplinary methods using a leading ethical framework, "accountability for reasonableness." "Interdisciplinary" research involves "researchers work[ing] jointly using a shared conceptual

framework drawing together disciplinary-specific theories, concepts, and approaches to address [a] common problem" (Rosenfield, 1992). Interdisciplinary research can help develop connections between discipline-specific theories, and lead to a shared conceptual framework that transcends traditional disciplinary boundaries (Kahn, 1993). To *evaluate* the case study descriptions we use "accountability for reasonableness." The "input" to the interdisciplinary research phase is the description of priority setting developed in the case study. We then compare the descriptions (what they "do") with the conditions of "accountability for reasonableness" (what they "should do"). Points of agreement will be considered "good" practices; gaps will be considered opportunities for improvement. These opportunities for improvement form the conceptual basis to guide the action research phase (below), the purpose of which will be to narrow the gaps and *improve* (i.e. make more fair) priority setting practices in the context. "Accountability for reasonableness" has been used to evaluate priority setting at the "macro" or health system level (see Ham, 1999; Ham and IcIver, 2000; Norheim, 2000). We used it to evaluate priority setting for health technologies in the Canadian health care system and concluded that Canada would benefit from capturing learning about priority setting that occurs in different organizational contexts, developing a platform to share that learning among different organizations, and adopting "accountability for reasonableness" as an ethical framework against which these empirical experiences could be assessed using a common set of concepts (Martin and Singer, in press).

Phase III: Improve

Next, since *describing* and *evaluating* do not cause change, a third step is to *improve* the priority setting process using action research to implement changes that flow from the evaluation. Action research is "research conducted in partnership with members of the community or setting in question with the specific purpose of bringing about structural or cultural change" (LeCompte and Schensul, 1999, p. 83). It "involves researchers and non-research partners in joint problem definition, selection of research methods, data collection, analysis, and plans and actions for use" (LeCompte et al., 1999, p. 125). Action research is an excellent way to capture and describe new types of knowledge while making change in an organization. Since action research is intended to respond to a problem important to the people involved, goals and strategies are best devised in collaboration with local research participants who are committed to the results (LeCompte et al., 1999). In the action phase of the research, the results of the case study *description* and the interdisciplinary *evaluation* are summarized and disseminated to the local participants. The local participants and research team then develop and implement strategies for *improving* priority setting in the local context (e.g., in a hospital). Although "accountability for reasonableness" does not specify how to improve priority setting in specific contexts, it is possible to identify strategies for improvement in relation to each of the framework's 4 conditions. For example in a hospital,

public accessibility may be improved by posting minutes from budget meetings on the hospital's web-site; or, public involvement may be enhanced by inviting former patients and local residents to sit on a budget committee. As in all aspects of action research, the development of strategies will be led by the local participants. We have begun to use the methods of action research to improve priority setting in hospitals (Martin et al., submitted).

Benefits of the Describe-Evaluate-Improve Strategy

To date, there have been very few descriptions of actual priority setting in health care institutions, no evaluations of priority setting in "meso level" health care institutions using "accountability for reasonableness," and no efforts to improve priority setting using the methods of action research. The *describe-evaluate-improve* strategy we have proposed is innovative because it is evidence-based and ethically grounded, and can provide an integrated strategy for improvement that synthesizes substantive/process criteria and "simple solutions"/"muddling through."

The *describe-evaluate-improve* strategy does not guarantee that each institution will achieve fairness, which is an abstract goal. However, since each institution is starting from a different "place" with regard to the goal of priority setting (i.e., fairness), the key outcome is not "where" they finish, but whether they improve. Fairness is a relative goal, lying along a spectrum. Even if a particular institution appears to "do" priority setting fairly, its processes may still be improved (i.e., made more fair). Moreover, improvements can emerge iteratively over several *describe-evaluate-improve* cycles. The goal of this strategy is to improve priority setting in health care institutions, not achieve predetermined standards.

There are several specific benefits to this strategy. For Board members, this strategy ensures the "due diligence" regarding priority setting that is required. For Senior Administrators, this strategy ensures evidence-based quality improvement in priority setting, and helps to foster the idea of a learning organization. For clinicians, it ensures inclusive political involvement of all stakeholders in policy decisions that affect health service delivery and patient care. Finally, because priority setting in health care institutions is a problem at every level of every health system, this improvement strategy will also involve capturing the policy learning that occurs so that it may be shared with decision makers in other contexts.

CONCLUSION

Recall that you are the CEO of a hospital (or Regional Health Authority, or Disease Management Organization, or Pharmaceutical Benefit Management Organization, or Managed Care Organization, or Public Health Unit, or Clinical Program). Normative approaches to priority setting conflict and are too abstract. Empirical approaches cannot tell you what should be done. There are two questions

you need to be able to answer for the sustainability of the organization and for your own job security: How should we set priorities in this organization? How do we know when we are doing it well?

The answer to the first question is: you need to follow a fair priority setting process. The answer to the second question will emerge through using the *describe-evaluate-improve* research-based improvement strategy described here.

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