Priority setting in hospitals: Fairness, inclusiveness, and the problem of institutional power differences

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Abstract

Priority setting tends to take place in health care settings that are hierarchical and politically complex. Fair processes, as defined for example by Daniels’ and Sabin’s accountability for reasonableness framework, have been identified as essential for securing socially acceptable priority setting decisions. However, power differences in the decision-making context can pose a serious impediment to fair priority setting in health care organizations. Comparatively little attention has been paid to examining the institutional conditions within which priority setting decisions are made. We review a case study of priority setting in hospital operational planning in Toronto, which had been designed by executive leaders to be broadly inclusive of senior and middle-level clinical and administrative leaders. We report three power differences that arose as limiting factors on the inclusiveness of the priority setting process. We argue that these findings have significant theoretical implications for the accountability for reasonableness framework and propose a fifth condition, the “empowerment condition”, which states that there should be efforts to minimise power differences in the decision-making context and to optimise effective opportunities for participation in priority setting.

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Introduction

Priority setting is a challenge for decision-makers across health care organizations. In the usual scenario, a small number of people “upstream” (e.g., Board members, managers) makes decisions that have significant “downstream” effects on stakeholders (e.g., staff, patients, community partners). In recent years, an ample literature has developed around Daniels’ and Sabin’s accountability for reasonableness framework (A4R), which identifies four conditions of a legitimate and fair priority setting process (Textbox 1). Perhaps its most significant innovation is its application of deliberative theories of democratic justice to the specific problem of health care priority setting. This explains its broad applicability across institutional settings and priority setting situations (Gibson, Martin, & Singer, 2004; Mitton & Donaldson, 2004; Martin, Shulman, Santiago-Sorrell, & Singer, 2003; Daniels & Sabin, 2002; Martin, Giacomini, & Singer, 2002; Norheim, 2000; Ham, 1999). The importance of fair priority setting processes is underscored by the limitations of previous attempts to apply simple technical (e.g., cost-effectiveness analyses) or principle-based (e.g., distributive fairness) solutions to the challenge of setting fair priorities (Paus-Jenssen, Singer, & Detsky, 2003; Holm, 2000; Russel, Gold, Siegel, Daniels, & Weinstein, 1996; Daniels, 1994). Moreover, experience shows that
priority setting is complex, often involving the balancing of competing goals (e.g., strategic/operational, academic/clinical, local/systemic) and values (e.g., equity vs. efficiency) in the context of multiple stakeholder relationships, limited resources, and the vagaries of political cycles (Gibson et al., 2004). Under such conditions, procedural fairness in setting priorities is essential for reaching socially acceptable decisions and for demonstrating public accountability.

Even though priority setting takes place in health care settings that tend to be hierarchical and politically complex, comparatively little attention has been paid to examining the institutional conditions within which priority setting decisions are made, or as Rudolf Klein has argued, to “getting the institutional conditions of the debate right” (Klein & Williams, 2000). While developing fair deliberative processes (e.g., A4R) is an essential piece of securing socially acceptable priority setting decisions, health care is characterized by significant differences in capacity for effective participation in the processes that shape these priorities. Power differences exist when some individuals and groups are better positioned than others to influence priority setting outcomes. If the interests of some individuals or groups are allowed to dominate the context within which priority setting decisions are made, then the outcomes of priority setting may fail to be fair. Specifically, power differences may have the effect of pre-determining the “relevant reasons” that inform priority setting and hence, undermining the overall legitimacy and fairness of the priority setting process. There are many types of power differences operative within health institutions (e.g., professional status, gender, ethnicity, historical dominance of particular health delivery models, patient vs. clinician), which can affect how effectively an individual or group can participate in priority setting processes. We focus in this paper on those power differences associated with institutional roles in the context of management decision-making about organizational priorities.

In this paper, we review a case study of priority setting in hospital operational planning, which had been designed by the executive leadership of the hospital to be broadly inclusive of senior and middle-level clinical and administrative leaders. We report three power differences that arose as limiting factors to the inclusiveness of the priority setting process. These factors suggest the importance of minimizing the effects of power differences in the decision-making setting to ensure fair priority setting. We argue that these findings have theoretical implications for the A4R model and propose a fifth condition—the “empowerment condition”.

### Methods

**Setting**

Sunnybrook and Women’s College Health Sciences Centre (S&W) is a large tri-site urban academic health sciences centre in Toronto. It was created in 1998 by an Act of the Ontario Parliament, which amalgamated three previously autonomous hospitals. In January 2001, an operational planning process was launched following the approval of a strategic plan in November 2000. An overview of the operational planning process is summarised in Textbox 2. At the time, senior management faced significant organizational challenges. There was mistrust across the three sites as the organization struggled to accommodate three distinct organizational philosophies and clinical legacies within a single corporate consciousness. There was a perception across the organization that no “real” decisions had been made since the amalgamation. And, there was pressure from the Board of Directors to focus S&W’s clinical activities (i.e., to specify “what business S&W was in”) and, with a significant budget deficit looming, to bring forward a balanced budget. Thus, a sense of urgency and uncertainty surrounded the operational planning.

### Textbox 1

The four conditions of “accountability for reasonableness” (Daniels & Sabin, 2002, p. 45)

- **Relevance condition**: Decisions should be made on the basis of reasons (i.e., evidence, principles, arguments) that “fair-minded” people can agree are relevant under the circumstances.

- **Publicity condition**: Decisions and their rationales should be transparent and made publicly accessible.

- **Revision and appeals condition**: There should be opportunities to revisit and revise decisions in light of further evidence or arguments, and there should be a mechanism for challenge and dispute resolution.

- **Enforcement condition**: There should be either voluntary or public regulation of the process to ensure that the other three conditions are met.
The operational planning process had two key objectives: (1) to develop a clinical service plan that identified clinical service priorities to guide resource allocation and to provide a clear direction for capital planning, and (2) to develop an operating plan based on these priorities that balanced the 2001/02 budget and advanced the strategic directions. In designing the operational planning process, it was clear to senior management that an inclusive decision-making process would be needed to secure organizational buy-in, particularly from the medical leadership.

Initial case study of priority setting

An initial case study of priority setting in the operational planning process, including methods and results, has been fully described previously (Martin et al., 2003). In brief, senior management recognized that lessons learned from using this novel approach to operational planning were too good to lose. Thus, they agreed to collaborate on a research-based quality improvement initiative to capture lessons for future priority setting initiatives (Martin & Singer, 2003). The operational planning process was described using qualitative case study methods and evaluated using accountability for reasonableness as a conceptual framework. This analysis led to eight recommendations to improve the legitimacy and fairness of priority setting at S&W based on the conditions of A4R (e.g., information on academic and community impact of decisions, a more comprehensive communication plan to engage external community as well as staff; a formal appeals process to resolve disputes), which were subsequently validated by the participants.

Re-analysis of the case study from the perspective of power differences

Upon a subsequent review of the interview and focus group data, power differences between decision-makers
emerged as a theme that had not been adequately captured in the previous case study analysis. From the point of view of the participants, the effort by senior management to be broadly inclusive of institutional leaders, while well-intentioned from the point of view of building trust and a corporate sensibility in a fragmented organization, was limited by a number of factors related to real and perceived power differences among participating decision-makers. Specifically, participants described factors they perceived to have contributed to the differential influence of some participants relative to others on the decision-making outcome. These power differences counteracted the procedural intent to be inclusive by inviting the participation of institutional leaders and by according each an equal vote. The case study raised two questions for us: (1) what specific factors contributed to power differences among participants in the operational planning process, and (2) what implications, if any, did the empirical data have for the accountability for reasonableness model?

All interview and focus group transcripts from the initial case study were reviewed. There were transcripts from ten individual interviews and four focus groups with a total of 45 people (including board members, executive leaders, senior managers, clinical and administrative directors, and medical department and program chiefs). Data were fractured by identifying chunks of data that related to the concept of power differences, which we defined as the differential capacity of individuals or groups to exert influence over the actions or attitudes of other individuals or groups in the decision-making process. Similar ideas were organized under overarching themes that emerged through constant comparison (e.g., individual capacity for decision-making/preparedness; interpersonal factors/decision-making context; real vs. perceived authority). These findings were validated by comparison with theoretical descriptions from the literature about the key sources of power differences in organizational settings, i.e., distribution of decision-making resources, organizational culture, and formal accountability and authority structures (Alexander & Morlock, 2000; Young, 2000).

In the next section, we outline these three factors and describe their effects on priority setting decision-making from the point of view of the participants.

**Results**

**Individual capacity for decision-making/preparedness**

Participants appreciated the opportunity to participate in the operational planning process even though this was a new experience for many of them. However, differences in preparedness among participants contributed to decision outcomes that were not well-informed by the available data/information and to the differential effectiveness of some participants relative to others in making decisions. Participants identified a number of factors contributing to their level of preparedness for decision-making of this kind: sufficiency of preparation time, availability of needed data/information, and skill set. Although materials were distributed a week in advance of the Decision Days, some participants found that this timeline was too short to review and understand the data. They also felt that they needed more information about each others’ clinical programs as well as more opportunities to ask questions and to seek clarification of issues prior to voting. One participant observed: “a fair-minded person would have difficulty making a decision with less than full information”. Health care organizations tend to be highly specialized and some clinicians expressed discomfort with the demands of decision-making because they lacked the relevant skill set or experience to make an informed decision:

It is something that I would say as a clinician I have very limited experience in—what is the value of this, what is the value of that—comparing oranges, apples, and bananas. But the denominator was valuation: if we do this, that saves X dollars and then we can apply those dollars over here. So, whether that is a shortcoming on my part as a clinician—I don’t have the experience in doing that. It certainly felt uncomfortable doing it.

Moreover, without the option to abstain, decision-makers questioned the reasonableness of the group’s decisions:

[We] did not have the information and you were not allowed not to vote either. That I think was unfair [to us] because we did not have the information to make decisions outside our sphere of interest.

While some participants were uncomfortable with being held accountable for decisions for which they were lacked sufficient information (e.g., “I felt a little uncomfortable with the authority which I was given [to make decisions with what we felt was inadequate information about other people’s areas]”), others expressed frustration that some decisions were being made by people who were perceived to lack sufficient understanding of the relevant issues:

Should the head of public relations or risk management have the same vote when you are changing the way to teach medical students and changing the way you are delivering high tech care? [No], because I don’t think they are as aware, I don’t believe they are as involved in the teaching and academic responsibilities of a university hospital.
Thus, although participants were generally supportive of an inclusive decision-making process, they questioned the reasonableness of the decisions that were made in the absence of an adequate knowledge-base and were driven instead by contextual factors (described below).

Interpersonal factors/decision-making context

Threading through the Decision Days was a drive for consensus. In part, this reflected a desire among many participants to support this novel process and the senior executives leading it, and to work together to define a corporate vision for the future. Consensus was reached on many decisions, however it was unclear to what extent this was an accurate representation of participants’ considered views. A “herd mentality” emerged, and participants described feeling pressured to conform and reluctant to vote in opposition to decisions or to express dissent or disagreement. The open voting procedure, while contributing to enhanced transparency in decision-making, was intimidating for many participants as it meant voting openly in plain view of their superiors:

When you have some very senior people put forward specific suggestions and then ask people who are in [a] direct line reporting mechanism to vote on these—again, I don’t believe this is a public forum. I don’t believe you’re getting a true sampling of opinions. I think it’s somewhat coerced to ask them to vote in a public forum where their votes are clearly acknowledged and their hands are held up one way or the other.

There were other more subtle forms of influence on voting behaviour. For example, voting was perceived by some to have been swayed by stronger speakers, whose effectiveness was reinforced by tight timelines and insufficient information:

Obviously we all need to have a corporate view, but then you need to do a lot more knowledge-building because then it becomes who articulates it the best, who made a point, or who was louder, bigger, fearful, more intimidating.

Finally, participants had the impression that dissent or disagreement was not welcome and might be construed as opposition to the process. For example, there was little time allowed for deliberation and discussion before voting, and there were no formal avenues to dispute decisions. In the end, some clinical programs elected to go outside the process entirely to lobby the Board of Directors or, in one case, use the public media to publicise their concerns about particular decisions. Medical leaders found decision-making particularly challenging because they felt torn by conflicting obligations, i.e., being “protector of their medical staff at the same time as being good corporate citizens”. This tension was further compounded by a perceived lack of trust among decision-makers in the post-amalgamation context:

You can’t have constructive discussion about what we should be doing because as soon as you do, there are so many different interest groups that still exist and... nobody trusts anybody. Everybody believes everybody has ulterior motives.

As a result, program leaders were put on the defensive to ensure the survival of their programs in a “game” that was described by some participants as “[deciding] whose ox it is to be gored”.

Real vs. perceived authority

Participants expressed a general willingness to share accountability for decision-making and to assume the corporate leadership role this entailed. Inclusiveness and equal votes meant that accountability was shared across lines of authority and that priority setting decision-making was more transparent.

It was a good way of getting people engaged in [the process] and no one could walk away saying “I never was involved, therefore I will not... But they were there and they participated.

The overt intent of the exercise was to build consensus across the senior leadership of the organization on clinical service priorities and operational decisions. However, as the process unfolded, it became apparent that they had only limited authority over these decisions and that real authority rested with a few senior executives. Many participants felt that many decisions had been pre-determined and that they had been called to “react” and “ratify” the vision of a few individuals in the organization rather than to participate collectively in building this vision or to make any real choices:

I think we were set up... Although we, on the overt side, had the sense that we were making choices, I think that those choices were very carefully orchestrated to ensure that the decisions that we made were the decisions that would drive the organization as they saw it.

The tactical value of voting was clear because it gave executive leaders a mandate to go forward and to claim organizational buy-in. However, as one executive observed, “voting gives you something you can hit people over the head with subsequently... It is a power tool, so that you [can say afterward], ‘Get with the program’”. There were a number of other factors that reinforced the impression that the group had
accountability but limited real authority over decisions. Participants were unsure how agenda items were selected and in particular how workbook data was used to identify deficit-reducing initiatives. In one case, a department head was surprised to learn that one of his programs was slated for possible divestiture. The no-abstention rule added a further constraint on decision-making that many participants found coercive and unreasonable given that it forced people to vote on and be held accountable for decisions even when they were not sure how to cast their vote. It would have been preferable, one participant argued, if there had been more transparency about the role participants were called to play:

Because the process was a very top-down process, it was a reaction to a specific vision... maybe given the constraints of time, given the constraints and difficulties of amalgamation, maybe that was the right thing to do, but it should have been acknowledged as such... [But] it was always described as the decision to be made by the group...

Discussion

"Accountability for reasonableness"—necessary but not sufficient

According to A4R, there is no other legitimate basis for agreement on priority setting decisions than the reasons that fair-minded people would accept as relevant and appropriate to meeting health care needs under resource constraints. Fair-minded people are defined simply as those who seek in principle “to cooperate with others on terms they can justify to each other” (Daniels & Sabin, 2002, p. 44). The search for relevant reasons often leads to a question of “whose” reasons are relevant to be included. Daniels and Sabin have argued that including a broad range of stakeholders as fair-minded participants in priority setting lends credibility to the “goal of having all relevant reasons considered” (Daniels & Sabin, 2002, p. 63). Inclusiveness so-conceived is not equivalent to “representation”. Rather, what matters most for A4R is not who is included so much as whoever is included should contribute to enhancing accountability for the reasonableness of priority setting decisions. Thus, the conditions of A4R ensure that decision-makers are limited in how effectively they can seek their own advantage or act in narrowly self-interested ways in setting priorities. In principle, then, to the extent that all decision-makers are constrained to play by the same rules of A4R, power differences among them should be neutralized significantly.

In reality, however, the conditions of A4R may not constrain all decision-makers equally in health care organizations. Much like the presence of a handicap will disadvantage some players relative to others in a team sport even if the same rules apply, so some decision-makers may be disadvantaged relative to others even if the same procedural conditions apply. The case study sheds light on a number of ways in which decision-makers’ capacity for effective participation in priority setting may be limited in health care settings and how these limitations may create openings for other forms of influence to determine priority setting decisions. The goal of “having all relevant reasons considered” cannot be achieved, for example, by including a range of stakeholders on a decision-making body or by providing them with an equal opportunity to appeal priority setting decisions, unless there is a reasonable expectation that their participation could be effective in informing the deliberation about priorities. Therefore, without this concept of “effective opportunity” (Young, 1999, p. 157; 2000, p. 23), the four conditions of A4R are not be sufficient to secure legitimate and fair priority setting decisions.

The “empowerment condition” of legitimate and fair priority setting

Based on our analysis, we propose a fifth condition of legitimate and fair priority setting—the empowerment condition. The empowerment condition states that there should be efforts to minimize power differences in the decision-making context and to optimise effective opportunities for participation in priority setting. For example, an iterative decision-making process that allowed more time for preparation, enabled people to build confidence about their decision-making skills, and incorporated opportunities for discussion of the available data/information; used a closed voting procedure with abstentions (e.g., secret ballot) and encouraged expression of divergent views; and defined participants roles and responsibilities clearly in relation to explicit decision-making context and to optimise effective participation.

One could argue that the A4R framework is complete in itself and cannot accommodate additional principles,
or that a fifth principle is unnecessary on the grounds that our findings concern the real-time challenges of implementing A4R rather than a limitation of the A4R framework, or finally, that effective opportunity is already implied in the conditions of A4R given its theoretical roots in a deliberative conception of democratic justice, so no additional condition is warranted. These arguments are unconvincing for the following reasons:

(1) In principle, the A4R framework can accommodate a fifth principle. Daniels (1999) has argued that, although necessary, the four conditions should not be assumed to be exhaustive of what might be required to support legitimate and fair priority setting in health care organizations. Moreover, the empowerment condition is qualitatively similar to Daniels and Sabin’s four conditions in that it functions at the same level of generality and provides normative guidance that can apply across health care settings.

(2) The “fair-minded” search for mutually acceptable solutions to priority setting problems means ensuring not only that relevant reasons are identified or solicited from stakeholders, but that there is actual effective uptake of these reasons in a way that informs and shapes priority setting decisions. Thus, the fifth condition articulates an essential feature of the “fair-minded” search for mutually justifiable terms of cooperation, a normative commitment which goes beyond mere implementation of the other four conditions of A4R.

(3) Several political theorists have argued that if deliberative democracy is committed to public policy-making based on the “force of the better argument”, then no individual or group of individuals should be allowed to coerce others through the use of brute force of physical aggression, social privilege, or other forms of unreasonable influence. Thus, conditions of “non-tyranny”, “non-coercion”, or “non-domination” are essential commitments of a deliberative conception of democratic legitimacy (Bohman, 1996; Habermas, 1998; Young, 2000). The fifth condition we propose is consistent with these views and warrants explicit articulation as a distinct condition.

Although we have focused on power differences related to institutional roles in management decision-making about organizational priorities, we expect that the empowerment condition should apply to other types of power differences that may be operative in health institutions. Different strategies may be necessary, however, to address these power differences in order to ensure fairness. It is important to emphasize that, in proposing the empowerment condition, we are not stipulating that all power differences must be eliminated in order for priority setting processes to be fair. Fairness is best understood, not as an either–or phenomenon, but instead as a matter of degree (Martin et al., 2002). For example, the participants described here readily acknowledged and commended the executive leadership for significant innovation in the operational planning process, including its ambitious attempt to be broadly inclusive of senior and middle-level clinical and administrative leaders, to make decisions on a more robust and transparent information base, and to capture lessons learned in order to inform future priority setting initiatives. Moreover, there are legitimate uses of institutional power differences in health care organizations related to, e.g., the formal structures of institutional authority and accountability, the appropriate use of expert knowledge, the enforcement of institutional policies (e.g., infection control, patient safety, informed consent) and professional codes of conduct, and compliance with legal obligations. Thus, it is not at all clear that the elimination of power differences can or should constitute a moral ideal in health care. Nevertheless, the empowerment condition does call for effective opportunities for stakeholder participation as a condition of legitimate and fair priority setting.

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