

# Evidence, Economics and Ethics: Resource Allocation in Health Services Organizations

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**I**magine you are a CEO of a health services organization (e.g., regional health authority, hospital, community care access centre, disease management organization). As CEO, you aspire to meet the health needs of your communities, within available resources, to advance your organization's strategic directions, including its mission, vision and values and (possibly) to fulfil an academic mandate. Your organization is experiencing significant strategic and budgetary pressures. Perhaps your organization has been asked to reduce waiting times for specific health services without reducing other service volumes or compromising quality. Perhaps demographic change in your local catchment area means existing health services capacity is no longer sufficient or appropriate. Or perhaps external factors (e.g., government directives, new technologies, regional health services restructuring, SARS) have placed constraints on your organization's ability to maintain existing health services and volumes. The Ministry of Health has informed you that no additional funds will flow to your organization in the near future, and your CFO tells you that she has exhausted fiscal strategies to release additional resources. You recognize the need to set health services priorities to facilitate resource allocation, but you are worried about how this will affect patients, staff and community partners. Also, your organization is up for re-accreditation this year, and ethics in resource allocation is among the Canadian Council of Health Services Accreditation (CCHSA) standards. How will you decide what your health services priorities will be? How will you know that they have been set ethically?

## INTRODUCTION: EVIDENCE-BASED MEDICINE, ECONOMICS AND ETHICS

Priority setting is a challenge for health services organizations across health systems. Because demand for health services exceeds available resources, health services priorities must be set to ensure resources are used appropriately to meet the community's health needs. Various approaches have been developed to assist decision-makers to set priorities in their organizations. The dominant approaches come from evidence-based medicine, economics and ethics.

*Evidence-based medicine* (EBM) focuses on effectiveness and appropriateness in allocating resources for health services to particular patient populations. When resources are scarce, clinical evidence can help to make allocation decisions that minimize waste of resources on ineffective or inappropriate treatments and maximize use of resources on "the right treatment for the right patient at the right time."

*Economics* focuses on efficiency from a population-health standpoint. When resources are scarce, an economic approach to priority setting seeks to optimize health (and non-health) benefits to the general population within available resources. Cost-effectiveness analysis is the most prevalent economic approach used by decision-makers.

*Ethics* focuses on fairness in allocating resources to meet health needs. When resources are scarce, an ethical approach to priority setting seeks a fair distribution of available resources among competing health needs.

Although healthcare decision-makers are increasingly successful in using clinical evidence and applying economic analyses to set priorities, they are less confident that their priorities are ethically sound. In recent years, demand for practical approaches to ethical priority setting in health services organizations has increased significantly. For example, the CCHSA specifies in its “Leadership & Partnership” standards that ethics should be considered in resource allocation decision-making, a stipulation that echoes the Canadian Council of Health Services Executives code of professional conduct regarding “ethical use of resources” (Canadian Council of Health Services Accreditation 2002; Canadian Council of Health Services Executives 2002). A recent national survey of Canadian health services policymakers, researchers and decision-makers identified “sustainable funding and ethical resource allocation” among the top 10 priorities for policy development and research over the next three years (Dault et al. 2004). This comes as no surprise to us at the University of Toronto Joint Centre for Bioethics. Over the last five years, we have observed a significant increase in requests for advice from senior managers and board members across Canada about how to set health service priorities fairly and how to implement ethical decision-making processes for resource allocation.

In this article, we describe an ethical priority-setting approach called “accountability for reasonableness,” which we have found to offer a practical framework for fair priority setting in health services organizations. We outline what we have learned about the practical steps decision-makers can take to implement it effectively in setting health services priorities. These lessons may be useful to your organization as it grapples with its own priority setting challenges.

### ACCOUNTABILITY FOR REASONABLENESS: AN ETHICAL PRIORITY-SETTING FRAMEWORK

*Accountability for reasonableness* is an ethical decision-making framework for fair priority setting (Daniels and Sabin, 2002). But what counts as fair? From experience, we know how difficult it is to reach agreement on what constitutes a fair outcome (i.e., distributive fairness), and specifically, on what distributive principles should be used (e.g., should priority be given to helping the sickest patients, to achieving the best outcomes, or to treating the most urgent needs?), how any such principles should be interpreted in particular situations (e.g., how much priority should be given to the sickest?), or how conflicts between principles (e.g., best outcomes versus sickest patients) should be resolved (Daniels 1994). This means that decision-makers must rely on a fair process (i.e., procedural fairness) to establish the legitimacy of priority setting decisions within available resources (Holm 2000; Daniels and Sabin 2002; Klein and Williams 2000).

Accountability for reasonableness identifies four conditions

of a fair priority-setting process (Daniels and Sabin 2002).

- **Condition 1: *Relevance*.** Decisions should be made on the basis of reasons (i.e., evidence, principles, values, arguments) that fair-minded people can agree are relevant under the circumstances. Fair-minded people are defined simply as those who seek in principle to cooperate with others to find mutually justifiable solutions to priority-setting problems.
- **Condition 2: *Publicity*.** Decisions and their rationales should be transparent and made publicly accessible.
- **Condition 3: *Revision*.** 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.
- **Condition 4: *Enforcement*.** There should be either voluntary or public regulation of the process to ensure that the first three conditions are met.

In our work with the accountability for reasonableness framework in health services organizations, we have found that an additional condition may also be required (Gibson, Martin and Singer, manuscript submitted for publication):

- **Condition 5: *Empowerment*.** There should be efforts to optimize effective opportunities for participation in priority setting and to minimize power differences in the decision-making context.

**Table 1. Putting ethical priority setting into practice: lessons learned**

Relevance	<ul style="list-style-type: none"> <li>• Develop a rationale for each priority-setting decision.</li> <li>• Use decision criteria based on your mission, vision and values.</li> <li>• Collect data/information related to each criterion.</li> <li>• Consult with internal/external stakeholders to ensure relevance of decision criteria and to collect relevant information.</li> <li>• Make decisions using a multidisciplinary group of people.</li> </ul>
Publicity	<ul style="list-style-type: none"> <li>• Communicate the decision and its rationale.</li> <li>• Use an effective communication strategy to engage internal/external stakeholders around priority setting goals, criteria, processes and decisions.</li> </ul>
Revision	<ul style="list-style-type: none"> <li>• Incorporate opportunities for iterative decision review.</li> <li>• Develop a formal decision-review process based on explicit decision-review criteria.</li> </ul>
Enforcement	<ul style="list-style-type: none"> <li>• Lead by example (i.e., ethical leadership).</li> <li>• Evaluate and improve the priority-setting process.</li> </ul>
Empowerment	<ul style="list-style-type: none"> <li>• Support people with leadership development and change management strategies.</li> </ul>

Together, these conditions describe an open and transparent priority-setting process that engages stakeholders constructively, ensures publicly defensible decisions and supports decision-makers' accountability for managing limited resources. The biggest challenge for decision-makers is how to implement these conditions in real-time priority setting – that is, how to put ethical priority setting into practice.

### PUTTING ETHICAL PRIORITY SETTING INTO PRACTICE

In this section, we offer some practical advice on how to use accountability for reasonableness to improve the ethics of real-time priority setting in health services organizations (see Table 1). This advice is based on lessons we have learned from working with decision-makers and other stakeholders to develop a more strategic and fair approach to health services priority setting under resource constraints. (An overview of a strategic approach to priority setting is described in Table 2.)

**Table 2. A strategic approach to health services priority setting**

1. Establish, refine or confirm the organization's strategic plan (i.e., mission, vision, values and goals).
2. Specify the responsibilities of the board and senior management in relation to the priority-setting process explicitly and upfront.
3. Clarify the programmatic architecture of the organization (i.e., what services are offered and how they are grouped administratively and programmatically) and create an inventory of current health services activities (e.g., volumes).
4. Assess each health service in terms of its alignment with the strategic directions and other relevant priority-setting criteria (e.g., community health needs).
5. Develop a priority listing of all health services to facilitate making strategic resource allocations.
6. Support decision-making with a legitimate and fair priority-setting process.

**Table 3. Priority-setting criteria (Gibson, Martin and Singer 2004)**

Criterion	Description
Strategic fit	The extent to which a health service contributes to advancing the strategic directions of the organization (i.e., "fit" with the organization's mission, vision, values and goals)
Alignment with external directives	The extent to which a health service is limited by government mandates (e.g., protected programs) and legislated obligations, and/or contributes to achieving regional or provincial health services objectives
Academic commitments: • Education • Research	Education: The role a health service plays in educating future health professionals and in facilitating the integration of education activities with health services delivery. Research: The role a health service plays in establishing and/or using best practices, generating new medical knowledge or developing and/or applying technological innovation.
Clinical impact	The extent to which health services volumes are sufficient to ensure clinical competency, patient safety and effective care, as well as considerations related to uniqueness of the service in the local/regional area and to quality of service provided
Community needs	The extent to which health services and volumes are consistent with health needs of a defined community (or catchment area), including present and future demands for service
Partnerships (external)	The extent to which a health service works in partnership with other organizations to coordinate delivery of care to defined populations (e.g., to enhance service quality, improve access, optimize resource utilization in the region or local catchment area)
Interdependencies (internal)	The extent to which a health service coordinates and collaborates with other health services within the organization to enhance quality or optimize resource use
Resource implications	The extent to which the resource context for health services delivery has implications for degrees of freedom in relation to prioritization, including funding source (e.g., base hospital budget, ministry of health volume-based funding, donation, revenue-generating activity), availability of staff (e.g., nurses) and capital resources (e.g., equipment, space), contractual arrangements (e.g., union contracts) and model of service delivery (e.g., efficient versus inefficient)

## 1. Relevance Condition

- *Develop a rationale for each priority-setting decision.*

The rationale should state explicitly what factors went into making the decision, including any decision criteria and data/information that were used. In the absence of an explicit rationale, there can be no way of ascertaining whether relevant factors were considered or of ensuring that such factors were applied consistently across priority-setting decisions. Having explicit rationales may also contribute to improved stakeholder relationships. For example, decision-makers in the Calgary Health Region felt that developing explicit rationales put them in a position to respond more effectively to stakeholder queries and to engage stakeholders constructively around the challenges of priority setting within available resources (Gibson et al. Manuscript submitted for review).

- *Use explicit decision criteria related to your mission, vision and values.*

We conducted priority-setting workshops with senior decision-makers in three Canadian health services organizations (Gibson, Martin and Singer 2004). When we asked them what criteria they would use to set health services priorities, their responses clustered around eight criteria, which they considered to be the most relevant decision factors (or “reasons”) in setting health services priorities in their organizations (see Table 3). The range of criteria identified in the workshops illustrates the competing goals, values and multiple stakeholder relationships that decision-makers must consider in setting health services priorities. The importance of aligning health services priorities with the mission, vision and values of the organization was clearly identified as essential for ensuring that operational planning would be driven by strategic considerations rather than by historical or short-term political considerations.

Priority-setting criteria should describe distinct concepts. Some organizations have found it useful to spell out subcriteria for each criterion. For example, the University Health Network (UHN) identified “educational strength” as a priority-setting criterion, broke it down into three defined subcriteria, and then refined each subcriterion further using a 10-point scoring scale (Case Example 1) (Madden et al. in press). Criteria should be consistently interpreted and applied to build confidence in the resulting decisions. Decision-makers at Sunnybrook & Women’s Health Sciences Centre (S&W) and the Ottawa Hospital tested their criteria on case examples before making decisions to ensure that criteria were sufficiently focused to draw distinctions between health services and also, that they were interpreted consistently across decision-makers. Even so, interpretation of criteria may continue to evolve through their use over time, which means that earlier decisions may need to be revisited to confirm their consistency with later decisions (see “3. Revision Condition” which follows).

- *Collect data/information related to each criterion.*

This may seem obvious, but some decision-makers have found themselves having drafted a great set of criteria, but making decisions on the basis of unrelated data/information. A disconnection between criteria and data/information not only makes priority setting more challenging for decision-makers, it makes priority-setting decisions less publicly defensible. Some organizations have developed tools, such as workbooks or business case templates, to capture data/information specifically relevant to each priority-setting criterion (e.g.,

## Case Example 1: Using priority-setting sub-criteria

The University Health Network identified six priority-setting criteria, including “educational strength,” to evaluate each clinical program element. Educational strength was broken down into three weighted subcriteria (uniqueness, quality and quantity) and refined further using a 10-point rating scale (UHN, 2001):

**Uniqueness:** Is the educational program within the program element unique? (40% weight)

- 1= Education program focuses on primary and secondary care and is widely available.
- 5= Education program focuses on tertiary and quaternary care and is one of few available.
- 10= Education program is recognized for its positive impact on healthcare in the province and is one of few programs available.

**Quality:** What is the quality of education within the program element? (30% weight)

- 1= Education program has a history of difficulties in mounting effective teaching programs and widespread student dissatisfaction.
- 5= Education program is recognized within the GTA for its quality teaching contributions.
- 10= Education program is consistently recognized nationally or internationally as a premiere teaching program.

**Quantity:** What is the impact of teaching quantity on the University of Toronto’s medical school? (30% weight)

- 1= Education program is very small and insignificant.
- 5= Education program is of mainstream importance.
- 10= Education program constitutes a large quantity of excellent teaching, making it an indispensable part of the University of Toronto medical school.

## Case Example 2: Stakeholder consultation and criteria development

There are a number of ways to engage stakeholders around the development of priority-setting criteria. Three examples follow.

**1.** The **Grand River Hospital** engaged both external and internal stakeholders in criteria development. Building on its success with broad stakeholder consultation in its strategic-planning process, the board of directors and senior management brought together a large group of internal and external stakeholders for a full-day workshop on ethics in priority setting. Participants included ethics committee members, senior managers, clinicians, pastoral care workers, board members, clinical and administrative directors/managers, community volunteers, representatives from local health organizations, the mayor's office and the ministry of health. Participants worked together to reach agreement on a draft set of priority-setting criteria, as well as the key process elements for fair priority setting at GRH in the context of its partnerships and community's needs.

**2.** The **Winnipeg Regional Health Authority** engaged its Community Health Advisory Councils (CHAC) in criteria development. Each CHAC represents two Winnipeg community areas and is composed of a diverse group of community members (e.g., consumers, family members, general public, professionals) and health organization members (e.g., clinicians, staff) from within those geographical areas. Their purpose is to provide "ongoing community input to assist the WRHA in its planning and decision-making processes respecting health, health needs, and priorities and health services in the Region" (Winnipeg Regional Health Authority 2002). After the board and senior management drafted a set of priority-setting criteria, the draft list was presented to each of its six Community Health Advisory Councils for input. Council members were asked to prioritize the criteria (i.e., give input on relative importance of each criterion), provide feedback on draft criteria definitions and suggest any additional criteria they felt were relevant to setting priorities in the WRHA. As a result of this consultation process, the WRHA priority-setting criteria were revised significantly, including the addition of two criteria (Winnipeg Regional Health Authority 2004).

**3.** **Sunnybrook & Women's College Health Sciences Centre (S&W)** engaged internal stakeholders in criteria development. Six broad priority-setting criteria (e.g., fit with vision, research excellence, clinical excellence) had been agreed upon by senior management and the Board of Directors. In order to develop relevant subcriteria and to specify information/data requirements, criteria subgroups were created. Each subgroup included senior decision-makers (e.g., senior management) and expert stakeholders (e.g., clinical and administrative managers, researchers, senior clinicians) from S&W. These subcriteria were incorporated into program workbooks and used to evaluate clinical program activities. Once programs had completed the workbooks, criteria subgroups reconvened to review each workbook and to identify a criterion rating score based on the subcriteria and data/information provided. To address conflict of interest concerns, criteria subgroup members were not permitted to review or evaluate their own programs.

service volumes, demographic data, impact analyses, qualitative data). Although the availability of relevant data/information is often limited by institutional decision support capabilities, a number of decision-makers felt that the identification of such criteria would be useful in defining the data/information needs of the organization and in focusing decision support activities (Gibson, Martin and Singer 2004).

- *Consult with internal/external stakeholders to ensure relevance of decision criteria and to collect relevant information.*

Stakeholder consultation is important for defining "relevant reasons" for priority-setting decisions in the circumstances. Research on public participation in healthcare priority setting has shown that, although public stakeholders are generally reluctant to be responsible for making priority setting decisions, they are interested in having input into how priorities are set, e.g. in developing the criteria that will be used to set priorities (Abelson et al. 1995). Some organizations have circulated a draft set of criteria to their internal (e.g., staff) and external (e.g., community health councils) publics for comment; others have involved stakeholders directly in drafting the criteria (see Case Example 2). A similar approach may be taken in defining relevant data/information. Focus groups with multidisciplinary groups of internal stakeholders or individual meetings with community partners may disclose valuable information about current health services activities, community health needs and opportunities for enhanced service quality or resource utilization, locally or regionally. For example, S&W discovered unanticipated opportunities for regional collaboration around health services delivery, including transfer of health services, during a round of meetings with external partners. Some organizations have formalized stakeholder engagement in their decision tools (e.g., by requiring program chiefs to consult with staff and account for whom was consulted), or, as the Ottawa Hospital has done, built available data/information into the workbook tools and allowing program areas to sign off on their accuracy.

- *Make decisions using a multidisciplinary group of people.*

A multidisciplinary decision-making group supports the goal of having all relevant reasons considered in setting priorities and ensures no one perspective or set of interests can dominate the decision-making

process. A key challenge for health services organizations is to determine how inclusive the decision-making body should be. In general, this group would include clinical and administrative leaders as well as academic leaders in institutions with an academic mandate. In some cases, it may also be appropriate to include public stakeholders. For example, Cancer Care Ontario included cancer survivors on its Policy Advisory Committee, which was responsible for recommending cancer drugs for funding (Martin, Abelson and Singer 2002). Inclusive decision-making can also be seen as a mechanism for enhancing the transparency of decision-making, for sharing accountability for organizational priorities more broadly across health services area, or for engaging powerful constituencies in a constructive manner (e.g., medical leadership). However, inclusion of some constituencies (e.g., public stakeholders) may require a critical mass in order to ensure their effective participation in the decision-making process (Martin, Abelson and Singer 2002). An appropriate balance between inclusiveness and decision-making effectiveness is clearly necessary – too many people can make decision-making cumbersome, too few people can make decision-making insufficiently informed or leave some constituencies feeling disenfranchised. Inclusion criteria should be transparent to offset any perception of arbitrariness in the selection of decision-makers, and stakeholders should be made aware of the full range of opportunities available to them for participating in the decision-making process (see “2. Publicity Condition,” which follows).

## 2. Publicity Condition

- *Communicate the decision and its rationale.*

Stakeholders – clinicians, patients, members of the public – will be in a better position to accept a priority-setting decision as fair if they can clearly see that the decision was based on relevant reasons under the circumstances. This means that the rationale must be publicly accessible and should clearly reflect how the decision is defensible in light of the priority-setting criteria and available data/information. From our experience, when priority-setting decisions seem arbitrary, this builds mistrust between decision-makers and stakeholders and can have a negative impact on staff morale.

- *Use an effective communication strategy to engage internal/external stakeholders around priority-setting goals, criteria, processes and decisions.*

Communications should focus on building stakeholders' understanding of (1) the scope and necessity of health services priority setting at this time and in the present healthcare environment, (2) the goals of the priority-setting process, (3) the criteria that will be used to set priorities and (4) particularities about the priority-setting process itself (i.e., who will make decisions, how stakeholders can participate, how the process will unfold, what outcomes may result). Communications should also identify

### Case Example 3: Iterative decision review

In November 2002, the [Saskatoon Health Region](#) launched a priority-setting initiative with the aim of taking a more strategic and fair approach to resource allocation in the face of budget constraints. They developed a set of priority-setting criteria, applied these criteria to their clinical and administrative areas and drafted rank listings of clinical programs and administrative service areas. Having ranked their programs, however, the organization suffered a crisis of confidence. Although administrative leaders were reasonably comfortable with the ranking of administrative services, there was a general lack of confidence among senior management and clinical leaders about the ranking of clinical services and its implications for resource allocation. For example, health promotion and disease prevention services ranked very high, whereas a number of key acute services ranked much lower than expected. At first, senior managers worried that they had not used the “right” priority-setting criteria (i.e., that the counterintuitive rankings were the result of using the “wrong” priority-setting criteria), and yet it was unclear to them what other criteria would be more relevant or appropriate to the task.

Senior management took steps to build confidence in the ranked lists. First, it requested a review of the prioritization process to identify any opportunities for improvement moving forward. This evaluation highlighted that the priority-setting criteria were too broadly defined and open to variances in interpretation, and that there were inconsistencies in how the priority-setting criteria were applied, particularly to the clinical program areas. Second, senior management brought clinical and administrative leaders together to present the evaluation results and to reach agreement on how to make improvements. A key improvement strategy was discovered through the open discussion, when one VP described how leaders in her portfolio had worked collaboratively to reach a shared understanding of each criterion and to review all workbooks together. Third, it was decided that a similar strategy would be used to define the priority-setting criteria more explicitly among senior managers and clinical and administrative leaders, and that the clinical rankings would be revisited in light of these refined definitions. Finally, senior management applied the refined criteria definitions to the clinical program areas and drew up a revised ranking of clinical services. Although health prevention and promotion continued to rank higher than acute services, senior managers had much greater confidence in the list and were able to make a strong case for protecting the budgets of the most highly ranked services and for allocating budget cuts elsewhere.

## Case Example 4: Formal decision-review process

In 2000, the University Health Network began an extensive strategic-planning process, which included setting five-year clinical activity targets for all clinical programs in light of the organization's strategic directions, academic requirements and health services needs of the local catchment area. The Planning & Priorities Council (PPC) developed draft clinical activity targets (e.g., growth/reduction of >15%, 0–15%, no change) for each clinical program based on explicit evaluation criteria (e.g., see Case Example 1) and available data/information. These targets along with the criteria rating scores were made available to the clinical programs. In October 2001, a formal "appeals" process was launched to receive feedback from clinical programs on the PPC's recommended five-year clinical activity targets as well as to provide UHN stakeholders with the opportunity to appeal these targets. The appeals process was open to both internal (hospital staff) and external (community advisory council) stakeholders on the basis of two appeals criteria: (1) new information or argument or (2) lack of due process.

In all, 15 appeals were submitted, including one from the community advisory council. All appeals were made on the grounds of new information or argument. Appeals were presented to the PPC in an open forum followed immediately by an in camera meeting of the PPC to finalize clinical activity targets. Of the 15 appeals, five resulted in a significant change in clinical activity target, four resulted in changes to criteria scores but no change in clinical activity target, and six resulted in no changes. Results of the appeals process along with a commentary from the CEO were posted on the intranet the next day (University Health Network 2002b; Madden et al. 2005).

openly and explicitly any ministry directives, academic commitments, protected services (e.g., infectious control in a post-SARS environment) and other working assumptions (e.g., strategic plan) that will limit the degrees of freedom within which priority setting will take place.

We have observed the use of a variety of internal communication tactics, including staff forums, newsletters attached to staff pay stubs, program visits by the CEO or other senior administrators, internal e-mail messages (e.g., updates, Q&As, glossary of key terms), intranet Web pages, tool kits to support middle managers in communicating with staff, and one-on-one meetings with program chiefs to communicate "bad news" before broadcasting priority-setting decisions more widely. Although external communication tends to be more passive, usually comprising short articles in the organization's public access newsletter, we have observed some notable exceptions in organizations that have reached out more proactively to their communities and partners. For example, the University Health Network developed an extensive strategic planning and clinical priority-setting website to keep public stakeholders informed (University Health Network 2002a); the Winnipeg Regional Health Authority met with its Community Health Advisory Councils (composed of healthcare professionals and members of the public) to get their input on priority setting in the region (see Case Example 2); the Kingston General Hospital held a press conference to talk about the need for priority setting in light of budget constraints and its plans to use a fair priority-setting approach (Lukit 2003); and following a controversial drug funding decision by Cancer Care Ontario, it was the public member (a cancer patient) of the Policy Advisory Committee who responded to media questions about how the decision was reached and the extent to which cancer patients' interests were duly considered.

**Silence may sometimes be perceived by stakeholders as executive indecisiveness or, cynically, as a retreat back into a black box.**

Decision-makers often express reticence about "going public" for fear of "making noise" for the Ministry of Health, and they emphasize judiciousness in timing the release of priority-setting decisions. It is important to remember, however, that transparent priority setting is not just about the transmission of information; it is also about keeping people engaged and invested in the priority-setting process. Silence may sometimes be perceived by stakeholders as executive indecisiveness or, cynically, as a retreat back into a black box. Prudence, in relation to the Ministry of Health, needs to be balanced against the costs of stakeholder disengagement.

### 3. Revision Condition

- *Incorporate opportunities for iterative decision review.*

Priority setting is best conceived as an iterative process. The priority-setting process should be flexible enough to allow priorities to change as new information emerges. During priority setting, there should be opportunities to revisit decisions and to validate the agreement reached, particularly if later decisions are dependent on previous ones, and there should be opportunities to revise decisions to include relevant new data/information or to correct errors. After priority-setting decisions have been finalized, it may be necessary to revisit and revise them in the future as the healthcare environment changes or as new data/information emerge. A priority-setting process that is flexible in this way has been described favourably to us by some decision-makers as part of the spirit of inquiry that characterizes the learning organization. It may also be important for building confidence in the priority-setting process among decision-makers and stakeholders (see Case Example 3). Whether during or after priority setting, decisions should be revised openly and transparently to offset the perception that they are simply the result of power plays made behind closed doors rather than the material outcome of new knowledge.

- *Develop a formal decision-review process based on explicit decision review criteria.*

A formal decision-review process is another key mechanism for engaging stakeholders constructively around difficult priority-setting decisions and for resolving disputes. The goal of decision review is to ensure priorities are reasonable under the circumstances based on available data/information. Decision-makers are sometimes concerned that a decision-review process may escalate conflict between stakeholders and decision-makers. Our experience so far is that this is not likely to be the case if the decision-review process is open and transparent and if it uses decision-review criteria that focus the review on bringing forward new data/information, correcting material errors in the original decision and addressing the material impact of any procedural inconsistencies (see Case Example 4). Although a decision-review process bears some resemblance to legal appeals proceedings or complaints mechanisms, it should not be confused with either of these procedures. There are a number of significant differences: (a) the purpose of decision review is not to prove wrong doing or assign blame, but instead to improve the quality of decisions made; (b) decision-makers and stakeholders are not understood to be adversaries, but instead to be partners in reaching reasonable decisions under the circumstances; (c) while there may be complaints about the decision-making outcome, the decision-review process focuses on the rationale for that decision and the process by which it was reached. Thus, we prefer to describe this formal review element as a decision-review rather than appeals process.

### Case Example 5: Quality improvement learning cycle

In January 2001, an operational planning process was launched following the approval of a strategic plan for [Sunnybrook & Women's College Health Sciences Centre](#). The operational planning process had two key objectives: (1) to develop a clinical service plan that identified clinical service priorities to guide resource and to provide a clear direction for capital planning and (2) to develop an operating plan based on these priorities that would balance the 2001–02 budget and advance the strategic directions. Over the course of two "Joint Planning and Decision Days," key institutional leaders (including senior managers, senior clinical and administrative directors and medical department chiefs and heads) met to make decisions using explicit decision criteria and extensive data/information collected in program workbooks designed for this purpose.

Senior management recognized that lessons learned from this novel operational planning approach were too good to lose. Thus, they agreed to collaborate in a research-based quality improvement initiative to capture lessons for future priority-setting initiatives (Martin and Singer 2003). The research-based quality improvement approach had three objectives:

1. *To describe* the operational planning process using qualitative case study methods based on interview and focus group data provided by participants, as well as relevant documents and observations
2. *To evaluate* the operational planning process against the conditions of accountability for reasonableness to capture good practices and opportunities for improvement
3. *To identify* improvement strategies to improve the legitimacy and fairness of future priority-setting initiatives

Eight recommendations to improve the legitimacy and fairness of priority setting at S&W were identified (e.g., a more comprehensive communication plan to engage external stakeholders as well as staff, a formal decision-review process to resolve disputes, more information on the academic and community impact of decisions) (Martin et al. 2003).

In October 2001, these recommendations were presented to participants at a "Joint Policy and Planning Day" for validation, and improvement strategies for each recommendation were discussed. When S&W launched a subsequent priority-setting exercise in January 2003, the recommendations of this initial case study were built successfully into its design.

#### 4. Enforcement Condition

- *Lead by example.*

Executive leaders play an indispensable role in setting the tone for ethical priority setting, establishing clear expectations for “fair play” applied to all participants and aligning the process and their actions accordingly. Behind-the-scenes lobbying and other attempts to exert political influence or to game the priority-setting process can be minimized considerably if the rules of fair play are enforced and reinforced throughout the process by executive leaders and between peers. By committing publicly to ethical priority setting, decision-makers may worry that this will lead to unreasonably high stakeholder expectations. Stakeholders themselves may worry that this is just a public relations ploy to mask a nefarious agenda behind a veil of ethical legitimacy. Effective leadership may be the difference between “ethical window-dressing” and ethical priority setting. An organization that endeavours sincerely to make allocation decisions fairly using an open, inclusive and transparent process cannot fail to build trust with stakeholders over time.

- *Evaluate and improve the priority-setting process.*

Evaluation strategies should be developed to ensure continued quality improvement and organizational learning. Fairness is best understood, not as an all-or-nothing phenomenon, but rather as a matter of degree. By evaluating priority-setting processes against the fairness conditions of accountability for reasonableness, both good practices and opportunities for improvement can be identified (Martin and Singer 2003). This can be accomplished in a number of ways: (a) before priority setting, by identifying opportunities for improvement in past priority setting and building these improvements into the present priority-setting exercise; (b) during priority setting, by monitoring the priority-setting process to assess alignment with fair priority setting and to allow mid-course corrections; (c) after priority setting, by conducting a formal evaluation to capture lessons for future priority-setting exercises (see Case Example 5). The priority-setting process can also be evaluated according to additional indicators of success. For example, decision-makers in three health services organizations identified outcome indicators, such as the effect of priority setting on organizational priorities and budget, on staff and on community members, as well as process indicators related to perceived fairness and overall efficiency of strategic resource allocation decision-making (Gibson, Martin and Singer 2004).

#### 5. Empowerment Condition


- *Support people with leadership development and change management strategies.*

Priority setting is both a learning process and a change process. Some stakeholders may experience this as an exciting opportunity to creatively define a vision of the future; however, most

will experience some degree of anxiety about what the implications of these changes will be. Moreover, health services organizations tend to be hierarchical and characterized by differences in capacity for effective participation in priority setting. Patients, staff and members of the public may feel particularly vulnerable in relation to priority setting. This can be alleviated at least to some extent by opening up the priority-setting process and engaging stakeholders constructively around defining the organization’s priorities.

Decision-makers are also vulnerable in the priority-setting process. In speaking with decision-makers, we learned that many of them have felt ill prepared to participate in decision-making (e.g., lacking the requisite skill set), intimidated by others in the process (e.g., peer pressure), or manipulated (e.g., feeling like a pawn on a chessboard) (Gibson, Martin and Singer, manuscript submitted for publication). Organizational capacity for priority setting decision-making may be strengthened through professional development (e.g., executive education, management skills) and leadership development (e.g., team-building). Support for dealing with organizational change is particularly important for middle management (including administrative and clinical managers), who are often not part of the decision-making group, but who play key roles in communicating with staff, in providing information about existing health services and in implementing priorities. For example, following an executive retreat on ethical priority setting, senior managers at Toronto East General Hospital requested similar sessions for both directors and managers to build capacity for integrating ethics into priority setting at all levels not just at the executive level of the organization.

#### CONCLUSION

Priority setting in health services organizations needs to go beyond evidence-based medicine and economics to ensure fairness in allocating limited resources. We have described a practical approach to ethics in priority setting based on the accountability for reasonableness framework. A fair process, such as the one we describe here, has a number of key strengths: (1) it is flexible enough to incorporate available clinical evidence, economic analyses and other relevant data – indeed, it establishes their legitimate use; (2) it engages stakeholders constructively around health services priorities; (3) it provides a basis for publicly defensible decisions; (4) it supports decision-makers’ accountability for ethical resource allocation. Decision-makers in health services organizations across Canada may find these practical lessons useful for developing fair and publicly accountable priority-setting processes and for engaging their communities more constructively around the challenges of resource scarcity. 

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