THE PRIORITY SETTING PROCESS
A Macro Perspective

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The Priority Setting Process: A Macro Perspective was first published in Swedish by the National Centre for Priority Setting in Health Care (PrioriteringsCentrum, 2003). The National Centre was established in January 2001 to gather, analyse, and disseminate information on priority setting activities related to health care in Sweden.

The original report was written to give Swedish readers greater insight into the similarities and dissimilarities of the macro strategies for priority setting as discussed in the international literature. The English version presented here is a full translation of the information in the Swedish report. Hence, parts of the text reflect the context of the prioritisation debate in Sweden.

International readers, we trust, will benefit in two ways from this contribution to the growing body of research literature in the field. First, the report synthesises several of the key perspectives and strategies on prioritisation in health care. Second, it provides insight into viable approaches toward prioritising health services in Sweden.

The National Centre for Priority Setting in Health Care distributes its series of reports to policy makers and providers in the health care and social sectors at the regional and local government levels in Sweden.

International readers are welcomed to contact the Centre for research-based information on healthcare prioritisation. Our research findings are available in published reports and on the Internet (http://e.lio.se/prioriteringscentrum).

National Centre for Priority Setting in Health Care (PrioriteringsCentrum)
Linköping, Sweden
September 2004
PREFACE

The mission of the National Centre for Priority Setting in Health Care (PriotiteringsCentrum) is to identify and monitor current projects in Sweden related to priority setting in health services (acute and chronic care) and to report on the knowledge base in the field. This report comprises the first stage of a project entitled “Methods in Priority Setting – Classification and Analysis” carried out by the National Centre for Priority Setting in Health Care with support from the National Board of Health and Welfare in Sweden. The term “methods” might lead us to believe that there are clear solutions to the dilemma of resource distribution in acute and chronic care. However, before we can consider applying particular “methods” or “techniques” in this context, it is necessary to better understand the prerequisites for pursuing the process by which priorities are determined. An understanding of the different “methods” requires a clearer understanding of the priority setting process itself. To clarify the process, this report explores several of the priority setting strategies discussed in the international literature. The next stage – presented in a later report – will link the various “methods” or “techniques” to this process in order to clarify their potential and limitations.

Peter Garpenby
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March 4, 2003
SUMMARY

This report is the first of a two-part report addressing different aspects of the priority setting process. The priority setting process includes standpoints, choices, information acquisition, information interpretation, decisions, and activities to win support for the various steps in this type of process. Setting priorities for collective resources requires conscious choices between different options, it takes place at different levels in a society, and it involves different types of actors (politicians, administrators, health care personnel, patients, and the public). This report presents several broad strategies from the body of international literature on priority setting in health care.

The *muddling through elegantly* strategy dissociates itself from general rules or formulas for allocating resources in health care since these tend to make the process static. Rather, health care personnel should have substantial freedom to make decisions about the distribution of resources. The public has limited insight into the priority setting process, but is given the opportunity to judge the results.

In the strategy for *rational decision making*, the acquisition of information is a key activity – usually the most important. Only the best available information, preferably acquired through scientific methods, should serve as a foundation for making decisions. Decision makers at different levels are expected to act rationally, i.e. guided by the available information they seek the optimum solution without allowing themselves to be influenced by extraneous factors.

The strategy for *pluralistic bargaining* implies that priority setting involves the ability to make socially acceptable decisions, and that this bargaining process must be repeated again and again. According to this strategy, we reach the best possible solution to the prioritisation problem through transparency, participation of many different parties in the process, the ability to consider and analyse opposing arguments, and finally viewing the decision as being “reasonable”.

The *community approach* strategy assumes that strain on society will increase to gigantic proportions if we attempt to finance all potential medical interventions. There is a risk that along the way we will stray from the essential values of what constitutes a “humane society” and a “good life”. A broad discussion should be initiated in the community to deal with the “impossible” value systems that lead in the wrong direction. The public should participate in this discussion, whereupon politicians and administrators need to develop “categorical standards” that are applied by health care personnel.
The *model of health care requirements* combines elements of the rational and the pluralistic strategies. It includes the clarification of goals and principles, the utilisation of good information, and the understanding that prioritisation must be a continuous process at different levels that also considers the viewpoints of lay persons (consultation of patients and the public).

*Explicit and implicit decision making* refers to the situation where elected officials are forced to explicitly indicate what should be financed while implementation of decisions at other levels involves an implicit process of prioritisation (not so much a conscious choice as a compelling condition). The transparency at one level serves as “protection” for the concealed process that must be carried out at other levels.

If we focus solely on the transparency issue, the strategies themselves do not appear to differ substantially, except on a few points. However, such a conclusion would be entirely erroneous – substantial differences begin to appear as we carefully scrutinise the various strategies.

This review suggests that we are not dealing with a single priority setting process, but rather with two processes – one concerning *internal legitimacy* and another concerning *external legitimacy*. Only when we make this sharp distinction does the content of the different strategies become truly apparent.

The process of internal legitimacy is characterised by the ability to identify a knowledge base (scientific) and arguments for establishing priorities based on that knowledge. This is the only way that knowledge-based organisations like health services can begin to gain trust for the priorities. The *model of health care requirements* describes a reasonable model for establishing internal legitimacy in a priority setting process.

*Pluralistic bargaining*, the *community approach*, and *muddling through elegantly* are priority setting processes concerned with improving the conditions for external legitimacy. However, they present two fundamentally different perspectives: to prospectively (ex ante) build confidence through guiding principles and a transparent and pluralistic decision making process, or to retrospectively (ex post) provide an opportunity to review and revise the results.

Of the strategies reviewed, two emerge as being more attractive in regard to developing a priority setting process for health services in Sweden. These are the *model of health care requirements* to assure *internal legitimacy* and *pluralistic bargaining* to enhance the conditions for *external legitimacy*. 
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1. INTRODUCTION

1.1 Background

Modern health services – driven by biomedical research – are accompanied by both opportunities and problems. A great technological revolution has given us the capacity to understand and intervene, especially in physical maladies. This, in turn, has created great expectations in the population. This direction became clear as early as the late 1800s, and confidence in the ability of science to combat health problems accelerated after World War II.

Society’s policies to promote health became synonymous with greater access to medical services. This was realised, in part, by support for medical research and education and, in part, by relieving the individual from the direct costs for care through collective financing – by taxes or insurance. In the transition to collective financing, an individual’s utilisation of care became separated from the economic transaction – the latter was taken over by a third party, which could be a public, tax-financed organisation such as a Swedish county council, a compulsory insurance arrangement, or a private insurance company.¹

Currently, it is uncommon for health services to be delivered in a free market. Priorities are set in a free market by having the individual determine how resources should be allocated for different purposes. Individuals themselves decide, e.g. whether the cost of care is proportional to the benefits, in exactly the same way as they decide about other goods and services. Do I need to go to the doctor for my back problem, or can I wait and use my money for something else?

¹ Both the orientation and the practical solutions varied among countries such as Sweden, Great Britain, Germany, and the United States. However, all of these countries believed strongly in medical research and medical services as a means to improve the health of their populations. One might get the notion that concern for the individual was the only motivator behind introducing collective financing of health services. In countries that chose public, tax-financed health service organisations, e.g. Sweden and Great Britain, there was a strong “paternalistic” feature in combination with rational considerations: health care was not viewed as an individual entitlement, but it should be managed through an effective organisation. In Germany, the introduction of compulsory health insurance in the late 1800s – predecessor to the current system – was part of a political manoeuvre by a conservative government to win the support of the working class. In the United States, the fundamental view was that individuals themselves should take responsibility for having adequate insurance protection, and public funds would be used only to provide care for groups that could not acquire their own insurance. See Fox 1986, Klein 1995, Freeman 2000.
For obvious reasons, many countries have decided to allocate health services according to principles other than those that apply to the free market, i.e. through individual decisions and self-financing. First, individuals have difficulty in knowing when health services will need to be consumed, which requires one to be prepared for future consumption. Those who are not prepared (who do not count on being affected by disease or accidents) are at risk. Second, individuals often have difficulty in determining the correct level of consumption, i.e. judging whether the price and quality of an intervention is reasonably proportional to its benefit. Insurance plans, both private and public, have been created to avoid this problem. Under insurance plans, a so-called “third party” manages the collective resources and “guarantees” that the producers of health services maintain an appropriate level of quality.  

Elements of individual demand nevertheless remain since individuals must take the initiative to use health services. However, a representative of a health profession, usually a physician, determines the need for care. The advance of medical science has enabled increasingly more people to receive adequate treatment, and hence hope has been transformed into need. If diseases cannot be eliminated, they can often be controlled, and the potential for improving the individual’s quality of life increases. The inherent “logic” of modern health care is that new innovation ignites new hope, which in turn is transformed into need.

In nations where collective financing of health services has become the norm, demands are placed on additional resources. To the extent that these resources do not keep pace with expectations (a combination of individual demand and professionally assessed need) a determination must be made on how to allocate resources. This process can be more or less well structured and explained to the public. We speak about a priority setting process when conscious choices are made between distinct alternatives.

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2 Third party financing of health services always assumes a balancing of resources. In the United States, for example, where health care is financed through different sources – private insurance paid by employers, public insurance system, and user charges – there are also restraining mechanisms. These are apparent not only through the 40 million Americans who do not have their own health insurance, but also through elements of user charges and diluted service (the quality of services varies according to the insurance coverage one has). In the publicly financed sector of U.S. health services – intended for the “poor” segment of the population (Medicaid) – the priorities are flexible since each state determines its poverty line, and this line changes if resources are insufficient (Rooks 1990). The official view, however, is that the United States does not prioritise. The reference is to explicit priority setting, where decision makers clearly indicate the way in which boundaries are drawn (Morone 1992). Some observers believe that even the United States must openly discuss priority setting. It will not be possible for even the wealthiest nations to expand health care services indefinitely (Callahan 1990a, 1990b).
The decisions have been transferred from the individual to a third party who might be the care providers themselves, an insurance organisation, or a political body.

1.2 Aim

This report is the first of a two-part report addressing different aspects of the priority setting process. The priority setting process includes standpoints, choices, information acquisition, information interpretation, decisions, and activities to win support for the various steps in this type of process. Prioritisation of collective resources requires conscious choices between different options, it takes place at different levels in a society, and it involves different types of actors (elected officials, administrators, health care personnel, patients, and the public). This report presents several broad strategies from the body of international literature on priority setting in health care.

Strategy implies a well thought out approach. The strategies presented here were selected by the author for the purpose of showing different perceptions on where the main emphasis should be placed in the priority setting process, and how the problem of difficult choices in health care should be addressed from a broad perspective. These strategies are not comprehensive, i.e. they do not treat all aspects of the prioritisation problem, they do not contain answers to all questions, and in many cases they may be difficult to compare with each other. The intent here – in addition to highlighting the core message behind the respective strategies – is to determine which elements in the various strategies are exclusive, i.e. can or cannot be combined with other strategies.

1.3 Prioritisation or rationing?

Earlier we stated that all health care systems, regardless of financing and production, apply “mechanisms” for allocating resources (between sectors, areas, technologies, and individuals). Refined strategies are seldom applied across all fields and levels in a society. Resources should always be allocated through a series of decisions of different types, and at different levels, where some will result in prioritisation and others will lead to rationing.

3 A strategy does not necessarily always involve activities and change. It can also involve a passive approach, leaving the current line of conduct and practice undisturbed.

4 Allocation should be viewed as an “umbrella concept” – resources are divided among different recipients. Usually resources are distributed based on prioritising or rationing, i.e. conscious decisions on rank order or decisions to not fully meet care needs. See Liss (2002) for a more thorough analysis of the concept.
Prioritisation involves conscious choices where the alternatives considered are ranked (according to selected criteria), while rationing is a decision not to fully meet a care need.\(^5\) In practice, this means that a prioritisation decision (to place A before B) may result in a rationing situation (in this context it is common to ration time, i.e. patients wait for their care needs to be addressed).

In the field of health care we can distinguish at least six different mechanisms that are used to manage the gap between available resources and potential care needs. These mechanisms may be used individually or, more commonly, in different combinations (Parker 1975, Klein et al 1996). Several have resulted from decisions at the national level, while others occur mainly at the regional (or corresponding) level, or at the hospital or clinical levels.

**Denial**

*Denial* means that some interventions, individuals, or groups are excluded from collective financing (taxes, public insurance, etc). The grounds for such decisions vary (e.g. a particular type of treatment is not necessary for the individual to live “a good life”, or costs are not reasonably proportional to the value of the investment). Denial is clearly a form of prioritisation (a conscious decision based on a judgement according to clearly defined criteria).

**Selection**

*Selection* fits in well with our definition of prioritisation, namely choosing among diseases, interventions, technologies, or patients and placing these in rank order. The decision making process itself may vary in terms of principles, information, and participants. We can base choices on, e.g. *fairness*, *need*, or *efficiency*.

**Deterrence**

This *mechanism* is commonly used to influence resource allocation in health care. Co-payments can be used to influence the demand for care (through differentiated fees for different levels of care, or through so-called *out-of-pocket ceilings* where *high consumers* of care do not pay more than a certain amount themselves). This category may also include the physical location of services (the individual’s demand can therefore be influenced by *entitlement* to subsidised travel to health facilities or home care visits by professional caregivers). Even inaccurate information or the lack of information about the possibilities to seek care can influence the individual’s demand.

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\(^5\) We apply the definitions of the concepts proposed by Liss (2002). One problem in the debate is that prioritisation and rationing are used to refer to mix of various phenomena. In particular, some of the works printed in English use the terms prioritisation and rationing synonymously.
Deterrence may be considered a form of rationing since the decisions create a risk that care needs will not be optimally addressed.

**Delay**

*Delay* is a common *mechanism* used by health services to manage situations where they are unable to serve everyone who demands services at particular time. Delay appears as waiting lists or queues. Different principles are used to manage waiting lists, e.g. “first come, first served” or “need” (Yates 1987). The individual can influence this situation if they have the possibility to change/choose care providers, or if they can use various options offered by private financing (e.g. self-pay or insurance). Delay is an example of care rationing.

**Deflection**

This *mechanism* is also common in health care and is expressed by forbidding or creating administrative obstacles to self-selection of care level. Rather, the individual moves from one care level to the next based on the assessment of professional caregivers or gatekeepers. In practice, the patient is required to have a referral or permission to access the next level of care. Deflection can be viewed as a form of rationing.

**Dilution**

Decisions in this case aim at lowering the quality of services, e.g. by having caregivers spend less time with certain patients or by eliminating certain tests. Dilution could also mean that patients are cared for by staff having a lower level of education (usually when personnel with higher education are in short supply). The uninitiated may have difficulty noticing *dilution* and assessing its consequences if they are not aware of the optimum possibilities. In this case, we can also speak about care rationing.

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6 It is important to point out that engaging staff with lower education to serve patients should not always be considered rationing. Quite possibly, the care needs of a patient can be better served by contact with staff having less education, but that which is adequate for the situation. A rationing situation occurs only when the decision to “substitute” staff is based on deficient resources and a conscious decision that prevents care needs from being optimally met.
2. THE PRIORITY SETTING PROCESS

What exactly do we mean by the priority setting process? According to Liss (2002, p 11) “prioritisation usually involves a combination of several choices and decisions.” He suggests that it is the combination of different choices and decisions that forms a process. The process can include different decisions depending on the situation. Ultimately, a decision is made on the rank order of the options – a type of decision that occurs in all priority setting processes. In its simplest form, the priority setting process may involve ranking two alternatives (e.g. A and B). Many different alternatives may, however, be included in the process (e.g. disease groups or treatment types). Prioritisation involves ranking alternatives based on a criterion (Liss refers to this as the prioritisation object, e.g. need or cost effectiveness). In reality, a mix of different criteria may apply, and hence the priority setting process may be difficult to analyse.

Notwithstanding these complications, every priority setting process includes choices and decisions where someone at some point in time chooses (a) participants in the process, (b) the options that should be considered, (c) the criterion or criteria that should be used, (d) the information that should provide a basis for decisions, and (d) the rank order that should be applied.

In its simplest form, priority setting can be described as a process where someone – either an individual or (more commonly) a group of decision makers – take various standpoints in multiple stages. Prioritisation can be pursued at different levels – in this context we usually distinguish between macro, meso, and micro. It is not entirely clear how this classification should be defined (it can refer to a hierarchical structure, e.g. national, regional, and local levels, but also to different types of decisions, e.g. choosing between health services and other sectors, among disease groups, individuals, or various decision makers, e.g. elected officials, administrators, and professionals. The following discussion touches only briefly on the priority setting process at the point of care, i.e. where individual decision makers rank patients at the individual level.

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7 The most comprehensive attempt to rank alternatives – in this case medical interventions – was probably that carried out in the state of Oregon (USA) during the early 1990s. It addressed publicly financed care for the “poor” residents in the state (Medicaid). Initially, 1680 alternatives were included, but the number was later reduced to 709. A mix of criteria was used (e.g. cost effectiveness and community values) to determine the ranking, where certain alternatives (interventions) could be financed while others fell “below the line” and were not eligible for public funding. See Honingsboum et al 1995. The trial, which appears to be unique in terms of the broad scope of prioritisation, is an example of a “basic package” or “positive list” – an approach aimed at deciding which interventions from a comprehensive range of options should be financed. Usually, priorities are set via a series of decisions at different points in time and different levels in society.
Rather, we envision a decision making process within an organisation that has a large core of decision makers that must prioritise among groups or activities. Primarily, our example applies to health services where at least some positions are established through decisions by political bodies. Here, the priority setting process is perceived to cover choices and decisions by many different types of actors.

A priority setting process of this nature includes at least four different phases:

**Agenda setting**  **Policy formulation**  **Decision making**  **Policy implementation**

### 2.1 Agenda setting

Agenda setting is an often an important, but often forgotten, phase in the process leading toward a decision. In this phase, we determine the questions that will later become subject to analysis and decisions. Here we also determined how a problem should be perceived, whether it is “technical” or “political” by nature. This decision can be of decisive importance for which actors will participate and what type of information will be collected to provide a basis for decisions (Baumgartner and Jones 1991). Obviously, a question or problem can be initiated in several different ways, e.g. through a “panic response” to something has gone wrong, or through careful consideration (Cobb, Ross and Ross 1976, Kingdon 1984). Who initiates a question, how it gains support (from which actors), and how it is initially defined and presented to a broader audience can determine how the issue is dealt with.

### 2.2 Policy formulation

In this phase, the different competing options are identified (in some cases this may have begun already in the preceding phase). Many options can be considered initially, but later reduced to those that can be addressed in making a decision. In this phase, we determine which alternatives should be covered by prioritisation (e.g. what type of treatments should be compared) and the criteria for prioritisation (what grounds should be used to set priorities). Here we determined how information should be collected and what methods should be used. Some alternatives will not be considered at all, they will be eliminated for various reasons – which is determined by how the participating actors perceive the problem and what obstacles they expect to meet along the way (Jones 1984). Those invited to participate in policy formulation can be decisive for the ongoing management of the issue.
Various constellations of actors will probably be found in different prioritisation situations.\(^8\) The composition is determined, e.g. by the type of expertise needed for a particular situation and the perceived need for support in the environment (legitimacy). In practice, policy formulation is a preliminary stage in a series of decisions that are important to the outcome that we often perceive to be the actual decision making.

### 2.3 Decision making

In this phase, a position is taken on the remaining alternatives. The number of actors involved in decision making may have been reduced. There may be different combinations of information for decision making: evidence (e.g. information collected by scientific methods) or values. The freedom to make decisions may be limited by various regulations or procedures that affect the range of options open to the decision makers. There is no particular form for an ideal decision making process, but the style used may vary depending on the conditions (Lindblom and Cohen 1979).\(^5\) Forester (1984) presents several variables that may be of importance for the type of decision making that is possible in different situations. He proposes five variables, the dimensions of which are presented below:

<table>
<thead>
<tr>
<th>Variables</th>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Actors</td>
<td>Few ------------------------------- Many</td>
</tr>
<tr>
<td>2. Environment</td>
<td>Closed environment ------------------- Open environment</td>
</tr>
<tr>
<td>3. Problem</td>
<td>Well defined --------------------- Vague</td>
</tr>
<tr>
<td>4. Information</td>
<td>Unequivocal ------------------------ Disputed</td>
</tr>
<tr>
<td>5. Time</td>
<td>Infinite --------------------------- Limited</td>
</tr>
</tbody>
</table>

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8 An extensive body of literature addresses the issue of participants in policy formulation and the search for solutions. The issue is considered to be important since the composition of participants is thought to determine how the decisions will be formulated and the consequences. These constellations of actors are referred to as “sub-governments”, “iron triangles”, “issue networks”, “policy communities”, etc. (See e.g. Jordan 1990 for an overview).

9 How realistic a “rational decision model” actually is (if it even exists) has been a topic of extensive debate for several decades. Briefly, the rational model can be described as a situation where we specify all goals, consider all alternatives in a neutral way, and pursue an optimum solution that involves the lowest possible resource utilisation to achieve the goal (the most cost-effective solution). Alternatives to this model have been proposed, e.g. “the incremental model” (Lindblom 1959) and “the garbage can model” (Cohen, March and Olsen 1972). While the rational model can be characterised as normative, i.e. it describes a desirable situation, the latter two are empirical models, i.e. they are intended to describe actual situations.
The type of decision making can differ depending on how the dimensions vary. It is the context that determines which type of decision making is possible, according to Howlett and Ramesh (1995). They refer to Forester’s categories and conclude that the conditions for “bold” decisions that involve comprehensive change are minimal in situations of “high complexity” where many different actors are involved, where there is a high degree of openness to the environment in combination with “severe constraints” involving vaguely defined problems, disputed information, and limited time. Only in situations of “low complexity” and “few constraints” does a more “rational search” for solutions become possible. Howlett and Ramesh (1995) present four main types of decision making that can be applied in different situations (Figure 1).

Figure 1. Levels of complexity and constraints in making decisions related to decision making style.

<table>
<thead>
<tr>
<th>Complexity of the Policy Subsystem</th>
<th>High</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Incremental Adjustment</td>
<td>Satisfying Search</td>
</tr>
<tr>
<td>Low</td>
<td>Optimising Adjustment</td>
<td>Rational Search</td>
</tr>
</tbody>
</table>

*Incremental adjustment* = are likely to occur where policy sub-systems are complex and constraints on decision-makers are high.

*“Satisfying” search* = where constraints are high but subsystems simple.
*Optimising adjustment* = when a complex subsystem exists and constraints are low, an adjustment strategy is likely, but one which may tend towards optimisation.

*Rational search* = where the policy subsystem is simple and constraints are low, more traditional rational searches for new and possibly major changes are possible.

### 2.4 Policy implementation

Prior to the 1970s, policy implementation was considered to be almost a “mechanical” activity and not particularly a problem. Several years later, studies began to show that the policy goals of complex programmes aimed at social interventions were not always realised (see e.g. Pressman and Wildavsky 1973). Since then, policy implementation has been viewed as a process with its own rules and conditions. Several factors are recognised to be important in this context. First, the type of problem addressed through decisions, including the size of the target group (change is usually easier to manage in limited target groups than in larger, more diversified groups) and the changes intended (behavioural changes in the population are much more difficult to achieve than, e.g. changes in rules affecting the social insurance system). Second, changes in social conditions influence the conditions for policy implementation (e.g. the age structure in the population affects both the health services and the social insurance system), as well as economic, technological, and political conditions. Third, public support for a specific change may be weak and may need to be influenced. However, it may be too late to consider such conditions in the implementation phase – it should perhaps have been addressed already when initiating the change (Howlett and Ramesh 1995).

The conditions for implementation vary depending on how clearly a decision is formulated and if those assigned to implement the decision understand its implications and have the will and resources to transform it into practice. The prerequisites are also influenced by the conditions in the organisation itself – whether the decision is in line with current routines and local practices.

Using prioritisation of health services as an example, there are major differences between a decision that requires ranking interventions that should be financed and those that should not (usually referred to as “core services”), versus a decision that vaguely states that health services should be allocated according to “need”, but does not specify the criteria to be used to determine need (usually referred to as “areas of priorities”).
2.5 *Sequences and standpoints in the priority setting process*

In applying the above reasoning to a potential priority setting process, what questions need to be addressed in the context of the different phases?

**Agenda setting:** How is the problem perceived? What support is there for this perception? Why is prioritisation viewed as a solution in the current situation?

**Policy formulation:** Which alternatives should we consider in prioritising? What criteria should be used to select among these options (e.g., care needs, cost effectiveness)? What information do we need and how should it be collected? Who should participate in this phase and who should make decisions about alternatives, criteria, and information?

**Decision making:** What prerequisites exist for the prioritisation decision itself, and what consequences does this have on interpreting the information and the opportunity to participate? What measures are needed to establish legitimacy for the decision?

**Policy implementation:** What support is available internally within the organisation and in the external environment to implement the decision? What constraints to implementation can be identified? How should implementation be followed up and the results evaluated?

<table>
<thead>
<tr>
<th>Agenda setting</th>
<th>Policy formulation</th>
<th>Decision making</th>
<th>Policy implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem perception</td>
<td>Alternatives</td>
<td>Interpretation</td>
<td>Support</td>
</tr>
<tr>
<td>Support Principles</td>
<td>Criteria</td>
<td>Participation</td>
<td>Constraints</td>
</tr>
<tr>
<td></td>
<td>Information</td>
<td>Legitimacy</td>
<td>Control</td>
</tr>
</tbody>
</table>

In Chapter 3 we will discuss several prioritisation strategies, and will consider how much guidance they provide on how to proceed through the different phases of the priority setting process.

2.6 *Explicit or implicit priority setting*

In reviewing the different strategies, we should distinguish whether they involve explicit or implicit priority setting. The concept of explicit priority setting is appearing more frequently in the debate. Increasingly (but not always) explicit priority setting is being advocated.
As discussed below (Chapter 3), some argue that priority setting should take place mainly away from public view. What do we mean then by explicit priority setting? Liss (2002) suggests several possible definitions, but appears to prefer the following:

“Prioritisation is explicit when the decisions, supporting information, and reasoning (including expected consequences) of priority setting are accessible to everyone wishing to see them.”

Liss 2002, p 21

In some cases it may be difficult to know whether or not a strategy actually fulfils these requirements (naturally it depends on how they are applied in practice). However, in most cases, it seems to be possible to classify the examples in terms of whether the aim is explicit or implicit priority setting.

3. STRATEGIES FOR MANAGING THE DILEMMA OF RESOURCE ALLOCATION

This chapter presents six strategies used in establishing a priority setting process (Figure 2). Four of these can be described as distinct strategies with distinct characteristics. The remaining two are combined strategies comprised of elements from the others.\(^{10}\)

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\(^{10}\) One strategy (“accountability for reasonableness”) is briefly mentioned in conjunction with pluralistic bargaining. It is not considered among the six because in many regards this strategy is similar to pluralistic bargaining.
Figure 2. Diagram of the strategies presented in this report.
3.1 Muddling Through Elegantly

This strategy is based on the assumption that resource allocation in health care – via prioritisation decisions – is a complex and sensitive territory that is difficult for decision makers and the public alike to enter. Health care should embrace a high degree of flexibility so that services can be adapted to the individual’s situation and needs. Health care resources should not be allocated according to general rules or “formulas” that tend to make services static. Rather, health professionals should enjoy substantial freedom to make resource allocation decisions.

The primary advocates of this approach are David J. Hunter, a British health researcher, and his American colleague, David Mechanic. Although these authors agree that resources must be distributed across different levels in health care, they are sharply critical of situations where political and administrative decisions prevent local adaptation by caregivers at the “micro level”.

Mechanic (1997) gives five reasons to be wary of “explicit rationing”:

- Explicit standards, once established, are difficult to change. This is not suitable in a system as dynamic as health care where new technologies are introduced and must be quickly adapted to individual patients.
- An essential element in health care is a doctor/patient relationship based on trust and dialogue. This relationship develops through a process of discovery and negotiation toward the best solution in a particular case.
- Patients are different. Their care needs and preferences vary, depending to large degree on whether they have experienced a particular illness and by age, gender, and other sociodemographic characteristics.
- Health services must be adapted to an individual’s – the patient’s and family’s – circumstances, e.g. concerning when and where services should be utilised. Here, flexibility is a critical element.
- When rationing decisions are documented, the conflict between different needs becomes visible which can destabilise the health care system and make it susceptible to political manipulation.

Hunter and Mechanic advocate a cautious approach where most of the difficult decisions on resource allocation are made without public involvement and debate (“muddling through elegantly” or “implicit rationing”). They reject national regulations that establish fixed principles for setting priorities.

11 It is not entirely clear what Mechanic (1997) means by “standards”. Presumably, he refers to rules affecting the treatment methods used (i.e. what third parties will reimburse). Mechanic views the Oregon experiment to be a primary example of “explicit rationing” with all the negative consequences thereof.
However, the two authors differ on this point (see below). Mechanic summarises the advantages of such a strategy as follows:

“The value of implicit rationing is its capacity to respond to complexity, diversity, and changing information in a sensitive and timely way. It builds on the strength of doctor/patient communication and sensitivity to the range of needs and preferences of patients whose life circumstances vary greatly.”
Mechanic 1997, p 86

Hunter and Mechanic would like to see responsible clinical decision making that balances patient benefits against costs. However, they concur that this type of priority setting cannot take place without some form of external control. The consequences of clinical decisions that concern priorities at the individual level must be open to discussion through both peer review and external audits.

Since prioritisation involves decisions affecting the individual, procedural rights should be in place to assure fair treatment. Hunter (1997, p 139) considers “standards for fair and consistent administrative procedures”. Such rules might require, e.g. that health service representatives should engage in a dialogue with the patient and be able to motivate decisions if questioned. In this case, democratically appointed bodies would be permitted to guarantee “procedural rights”. 12

Hunter opposes making decisions at the national level on prioritising among disease areas and technologies. These areas should not be subjected to public debate on prioritisation, and the public should not be involved in these decisions. He is sceptical toward allowing elected officials, administrators, or the public influence the decision process on such issues – if clinicians are forced to “abdicate”, the risk increases that irrelevant criteria, e.g. age and lifestyle, will influence the priority setting process. A public discussion might possibly be conducted on the distribution of resources between health services and other sectors in society. He says that, in principle, an open debate on prioritisation and rationing is undesirable since it creates a risk of damaging public confidence in the health care system.

12 Hunter et al developed their views on “procedural rights” in health care in different contexts. They do not want to see “absolute rights” to health care that are impossible to manage in a publicly financed system. Rather, the focus is on procedural rights, i.e. the opportunity for individuals to have their cases heard and dealt with according to clearly established principles (Coote & Hunter 1996).
“There is a particular threat to the notion of ‘common goods’ or ‘collective provision’ which is the glue holding the NHS (National Health Service) together. Widening the debate about rationing could give rise to a new individualism or narrow utilitarianism which may weaken the collectivist ethos which underpins the NHS”

Hunter 1997, p 138

Mechanic (1997, p 87) however proposes that “government must establish some limits on the proportion of its resources that go to medical care compared with other sectors”. He goes further than Hunter by permitting politicians and administrators the right to decide on the acquisition of expensive technologies that favour a few and on policies that should apply to new technologies that require major resources.

“They [government and administrators] can decide that certain interventions are of so little effectiveness and utility that they should not be included in the medical care benefit package or that drugs and other interventions that have no better outcomes than less expensive ones should be excluded.”

Mechanic 1997, p 87

Such guidelines may help physicians who are being “pressured” by patients (although it is unclear who should authorise the guidelines and at what level they should be developed). Hence, Mechanic retreats from the position that resource allocation decisions should be kept only at the clinical level. Rather, he appears to lean toward a strategy that favours “a proper balance between explicit and implicit approaches” (p 87). Nevertheless, he says the rules should not limit the physician’s clinical freedom in situations where the patient’s best interest would be served by special solutions.

Hunter (1997, p 145) also softens his position when he discusses the possibilities to enhance democratic input in economising health resources at the local level. All decisions on resource allocation cannot be made via interaction between physicians and patients, but the “commissioning of health services according to locally determined priorities, together with other public services which have an impact on health, is an appropriate matter for a publicly accountable, representative body.”

Hunter suggests that important decisions should be made at the local level, and the public should have the right to demand accountability for the results of prioritisation decisions. Allowing the priority setting process to be played out on an open stage does not, however, go against Hunters message.

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13 In this case, he refers to the situation in the British National Health Service (NHS). He discusses the possibility to replace the “health authorities”, which are appointed to implement state directives, with directly elected bodies or “local authorities”.
However, it is not clear if he believes that prioritisation decisions should be accessible to the public.\(^\text{14}\)

### 3.2 Rational decision making

Proponents of this strategy start from the assumption that decision makers are goal oriented, and that the intent of decision making is to find the best possible way to achieve a well-defined goal. Rational decision makers look for the optimal solution, i.e. the best solution within the framework of resources at their disposal. In this type of situation, knowledge about alternative courses of action and outcomes of implemented decisions play an important role. In rational decision making, the acquisition of information is a key activity – usually the most important. Decisions are based solely on the best available information, preferably acquired through scientific methods. Decision makers at different levels are expected to act rationally, i.e. they should use the available information to search for the optimum solution without allowing themselves to be influenced by extraneous factors. The proponents of rational decision making take a negative view toward the influence of pressure groups and other non-relevant special interests. Views toward politicians are usually negative among proponents of this strategy. In establishing goals for activities, some allowance should be made for input of values, but thereafter a rational search for solutions should dominate (Alexander 1986). The sceptical attitude toward certain types of decision makers – politicians and representatives of the “power structure”, e.g. professions – is based on the notion that the former are vague, diffuse, and contradictory in their actions while the latter want to “protect” their territory.

A proponent of the “rational strategy” toward resource allocation in health care is Alan Williams, a British health economist.

\(^{14}\) There are some problems in following Hunters reasoning on this point. Clearly, he opposes any type of centralisation of priority setting decisions, and he sees the British National Health Services (NHS) as a cautionary example. Instead, decision making should be decentralised to directly elected local bodies with whom the public can later discuss the outcome of the priority setting process and can thereby hold the decision makers accountable. Also, it would be difficult to keep prioritisation decisions secret if the responsibility is placed with directly elected democratic bodies. Hence, this strategy would drift toward “explicit prioritisation”.
He is active in the debate and advocates that the decision making process would benefit from both greater transparency and more knowledge:

“One of the main obstacles to progress is the clash of cultures between analysts who see the need for clarity and openness, and politicians (including the professional wielders of power within the health care system) who rightly feel vulnerable when their muddled thinking and inadequate evidence base are exposed to external scrutiny”.

Williams 2000, p 20

Even though the acquisition of good information, with the help of scientific methods, is a central theme in the “rational strategy, these proponents acknowledge that basic values in society differ, and therefore the goals of health services can be established only after public debate. Goals might include, e.g. “improving the health of the population” and/or “reducing the inequities in health care”. It is important that goals are not contradictory, and that they are clearly expressed so they can be understood by decision makers at all levels.

The public plays a role as a source of data at the aggregate level (Williams 1999). The information base may consist of, e.g. data from epidemiological studies or data on care utilisation. It may also contain subjective data that reflects quality of life. In cases where the public is consulted, there is an underlying assumption that the individuals have certain preferences and experiences that can be collected and aggregated, e.g. the perceived benefits of different treatments.15

The “rational strategy” does not focus on decision making itself, but rather on the efforts to strengthen the knowledge base for making individual decisions. Having access to adequate information also reveals the less-than-optimal ways of allocating resources – better equipping the various actors for the tasks facing them. What type of information is necessary for prioritisation decisions in health care, according to the proponents of the rational model? Three types of information are frequently mentioned: (a) epidemiological data, (b) data on the effects of medical interventions, and (c) data on the costs and effects on the individual’s quality of life.

15 Ignoring public opinion would be unfamiliar to the proponents of the “rational strategy”, particularly in conjunction with prioritisation of health care. They can hardly be accused of being “anti-democrats”. To the contrary, this model has an element of “direct democracy”, in the sense that the will of the people should be expressed by quantified data collected directly from the citizens, not via perceptions that have been filtered through politicians or professions (Williams 1999, 2000). Or as Alan Williams says: “…what do we know about the values of the general public on all these matters? Are health service professionals good proxies for the views of the general public, or do they have special interests of their own which might bias their judgements, wittingly or unwittingly?” (Williams 2000, p 16).
Epidemiological data
Epidemiological data include the distribution of morbidity and mortality in the population – among geographic areas, age groups, and social groups – and information on the causes of death and disability. This information can provide a basis for estimating the relative need for health services, i.e. needs assessment.

Data on the effects of different methods (evidence based interventions)
This data reflects knowledge about the positive and negative effects of various medical interventions. Obviously, this knowledge is beneficial in prioritising resources. If the data show that a particular method is ineffective, or less effective, than other methods it can be retired from the arsenal of health services, thus freeing resources. The problem of prioritising among different interventions then becomes easier – at least in theory. If, however, studies show that patients benefit from a new technology, then the problem is reversed, i.e. the health services have yet another effective technology that requires decisions on whether or not it should be included under collective financing.

Cost-effectiveness analysis
Since the field of economics deals with the efficient use of resources, economic methods are naturally used to develop a basis for setting priorities. The point of departure in this context is to identify costs and the benefits (revenue for society as a whole), applying various methods in health economics. Cost-effectiveness analysis investigates whether additional resources will lead to greater benefits (e.g. in terms of health). There are two variants of cost-effectiveness analysis, one where benefits are estimated in monetary terms (cost-benefit analysis) and another that measures other types of utility, primarily the effects on health (cost-utility analysis).

In its simplest form, cost-effectiveness analysis shows which interventions (medical or other care-related) provide the greatest health gain at a given cost. The health effects can be expressed in terms of life-years gained or other relevant measures of health improvement, while the “costs” include all relevant costs regardless of who is affected: treatment costs, travel costs, lost work time, etc. In cost-benefit analysis (CBA), the benefits are traditionally determined by estimating the individual’s future earnings in monetary terms. This would be viewed as a problem when the analysis is applied to health services, particularly in systems where “equity” is perceived as a fundamental principle. To develop more sophisticated tools that are more appropriate to use for cost-effectiveness analysis in health care, other utility measures have been applied. The most recognised is cost-utility analysis in conjunction with measures such as quality-adjusted life-years (QALYs).
3.3 Pluralistic bargaining

We have no fundamental principles or decision making rules for prioritisation of health care resources. Likewise, we have no specific “techniques” or “formulas” to solve the complex questions of prioritisation. Consequently, the scientific community cannot offer satisfactory “tools” in this context. It is never inappropriate to acquire good information for making decisions. However, our main problem in prioritisation is not the lack of information, but the ability to manage and interpret the information that we have. The imbalance between supply and demand of health services is a problem that cannot be solved once and for all, but we must aim to create better conditions for the institutions appointed to manage prioritisation. Ultimately, prioritisation deals with the ability to reach socially acceptable decisions, and this process must be repeated time and again. Transparency, the participation of many different parties in the process, the ability to compare, contrast, and analyse different arguments, and finally the capacity to make “reasonable” decisions – this offers the best possible solution to the priority setting problem.

In summary, these are the basic elements of the strategy usually referred to as pluralistic bargaining. The most prominent proponent of pluralistic bargaining is Rudolf Klein (1993, 1998, 2000), a British health policy researcher. At times, the model is described as a bargaining solution between two selected parties (one envisions protracted, late-night negotiations in closed rooms – a type of “corporatism”). This, however, is a misconception since the point of departure is open argumentation aimed at reaching a solution that the public can accept.

“The aim must be to build up, over time, the capacity to engage in continuous, collective argument.”

Klein 1993, p 309

The strategy is based on the realities within a society having a predominantly public-financed health system, where important decisions must be made through a mix of political, administrative, and clinical decision making processes. Under such conditions, the entire system depends on previous decisions. According to Klein, one cannot expect rapid change, regardless of the type of information presented. Cautious, step-by-step change of the prevailing balance of activities in health care is more realistic, i.e. incrementalism.

16 “Corporatism” refers a decision process where selected participants are given a monopoly in representing certain interests in society, and they are expected to control their respective areas of responsibility. The most recognised definition is found in Schmitter (1974).

17 This idea is not new, but draws heavily from Charles Lindbloms criticism of “rational decision making”, where the alternative he proposed already in the 1950s was to allow
Decisions at various levels in the system influence each other, which requires managing the prioritisation problem at all levels (general policy, purchaser, and clinical). Hence, it is not sufficient to develop principles at one level, or to acquire knowledge about costs and benefits that can be applied across the board at all levels. The decisions that have established the current distribution of resources, and the arguments behind these decisions, must be publicly reviewed and scrutinised, and conflicting values and ethical principles must be openly discussed. This approach should address all levels – the political, the administrative, and the clinical.

The proponents of the model do not completely dismiss the benefit of better information as a basis for priority setting decisions, but suggest that occasionally the evidence on effects and cost effectiveness can play a decisive role – but only in exceptional cases (Klein 2000). Rather, there is a need to make use of the knowledge from the political system and the administrative elements of health care that show which decisions work best in practice, and their consequences. The capacity to learn from decision making process (i.e. policy learning) must be exercised. This includes the ability to draw on the effects of earlier decisions, even to the extent that participants can change their preferences based on the outcome of previous decisions.

Klein does not show how existing institutions should be changed as discussed above, and it is not clear how the decision making process should be developed to become more pluralistic. However, he suggests that the problem up to now has been that the priority setting process is not pluralistic enough, and that it is dominated too heavily by the medical community. The consequences of this should be that other interests should be more prominent, but who should represent these interests? Klein is clearly sceptical of some attempts to collect data, e.g. on preferences, from the public through simple opinion surveys (Klein 1993). A weakness with the pluralistic strategy is said to be uncertainty concerning which parties should participate in the discussions (health care staff, patients, public?), what weight should be given to various opinions, and what criteria should be applied in making decisions (Coast and Donovan 1996, Petrou and Wolstenholme 2000). The model has also been criticised for placing too little emphasis on systematic assessment (Williams 2000). A bargaining solution, however, increases the potential for decisions actually being implemented, which is not always the case when an abstract principle forms the basis for a decision, according to Coast and Donovan (1996).

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various interested parties to find a pragmatic solution together, i.e. “pragmatic agreement among stakeholders” (Lindblom 1959).
If the pluralistic model should include more participation from patients and the public, how should this be done? The question of how to design participation is difficult at the policy level as well as at the purchaser and clinical levels. Compared to organised groups, representatives of the public at large will always be at a disadvantage in making their voices heard and being able to defend their position. Special measures would be required for the public to have meaningful input in a pluralistic model, according to Donovan and Coast (1996).

Likewise, in this context, the participation of health care staff is not without problems. How should the staff members be represented, and what role should they play – simply present “scientific evidence” or actually participate in decision making. In the latter case, the question is how to achieve representation that is perceived to be legitimate, both internally (within professional groups) and externally (in society at large).

Proponents of the pluralistic strategy have not specifically described how existing institutions could be transformed to make the decision making process transparent and enable different parties to participate. However, the question of who should participate, and on what conditions, should not be overplayed since the “illumination” of arguments and evidence, in combination with transparency, form the core of this strategy. Hence, it appears to be less important to discuss how the public and staff should be represented. Rather, we should focus on how to design the process so that it receives broad support. In this respect, pluralistic bargaining seems to be closely related to the concept of fair processes developed by American philosopher Norman Daniels and physician James Sabin (Daniels and Sabin 1997). They presented several conditions that characterise a fair priority setting process.

18 A question that can arise is whether the public should be consulted separately or together with other parties in discussions about priorities. We have little experience with this type of representative body. Is the intent to gather information on preferences that represent the population at large or to involve “responsible citizens” in discussions where arguments and evidence are thoroughly examined? There is a wide difference in the methods that can be used in these situations (Garpenby 2001).
19 The relationship was discussed in Klein 1998 and highlighted in a personal communication with Rudolf Klein August 15, 2002.
These have become recognised under the collective title of “accountability for reasonableness” and can be briefly described as follows:

a) the principles for prioritisation decisions must be made public (publicity condition)
b) these principles must be perceived to be relevant for the situation by those trying to establish conditions for collaboration that are justified (relevance condition)
c) there must be mechanisms to question decisions and revise them in light of new evidence and arguments (appeals condition)
d) there must be either voluntary or public regulation of the decision making processes so that the above conditions (a, b, c) can be fulfilled (enforcement conditions).

This model will not be discussed further here, but is presented in greater detail in Daniels and Sabin (2002).

3.4 Community approach

The aim is to develop a strategy that will, in the long run, make it possible to limit the consumption of health services since supply is never perceived to be fully adequate. The strategy begins with the assumption that the strain on society will reach gigantic proportions if we attempt to finance all potential medical interventions for the entire population. There is a risk that, along the way, we will stray from the essential values of what constitutes a “humane society” and a “good life”. The idea that we could use a “mechanical formula” to solve our serious problems of resource allocation in health care is rejected (a simple solution cannot be achieved through economic analysis, technology assessment, philosophy, or politics). Rather, a broad discussion should be initiated in the community to deal with the “impossible” value systems that lead in the wrong direction. This strategy has been promoted by the American philosopher, Daniel Callahan (1990a).

Callahan suggests that our perceptions of, and our relationship to, health services is permeated by values that can be critically questioned, e.g. wanting individual free choice, applauding medical advancements, believing in continuous improvement of quality, denying the effects of ageing on humans, and aspiring to eliminate pain and suffering at any price. These values are defended by the various interest groups representing professions, patients, and the research community.
Rather than allowing the priority setting discussions to deal with the services that health care produces, or is expected to produce in the future, Callahan says we must address fundamental normative questions such as: “What constitutes a good and meaningful life?” and “How can health services contribute to a good and meaningful life?” He refers to this as “the cultural level” and claims that values at this level are most important to change. Other levels deal with “our right to health care” and “who should produce and finance health care” (entitlement level) and the level where care is produced by different professional groups (institutional level). According to Callahan, we must change our thinking at all levels, but we need to begin at the most important – the cultural level.

He envisions an “open” dialogue in society where the public participates. Citizens should be presented with well-defined alternatives and have the opportunity to weigh the advantages and disadvantages. A combination of debates, public forums, and educational programmes are possible. The process leading up to the final decision should involve all important interests: physicians, other health professionals, patients, political officials, health care administrators, and the public. Callahan then envisions that policy making bodies draft “general guidelines”, which are later refined through the administrative process, and ultimately lead to what he calls “categorical standards”.

There are several reasons why this approach appears to be the best, according to Callahan. It is impractical, on a large scale, to limit access to care by “rationing” via decisions at the individual level. Callahan believes that clinical decision makers, mainly physicians, should have room to negotiate, but he believes that it would be inappropriate to prioritise and ration care at the bedside (bedside rationing). Naturally, there should be some provisions for physicians and patients to jointly decide on appropriate care within certain limits. But the boundaries should be clear enough that physicians do not have to take responsibility for decisions that are actually made at the community level. Physicians must learn to apply categorical standards that, in effect, limit professional freedom.²⁰

Another important reason for introducing categorical standards rather than attempting to set priorities at the clinical level is to control their application. Standards can be discussed openly, and they can be applied without involving extraneous factors.

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²⁰ Callahan suggests that physicians who act within given limitations should not face the risk of having patients test their case in a court of law. He makes this observation given the situation in the USA where judicial cases involving medical interventions are common.
For prioritisation to be possible, we must move away from the *individual perspective*, according to Callahan. We must select *groups of individuals* as the level where priorities should be set. He refers mainly to age as an appropriate criterion, and believes that it is possible to rationally determine what different age groups would need in order to live a good life.\(^\text{21}\) Hence, we can also find a “balance” among interventions in the various age groups. However, this assumes that we can move away from thinking about “individual needs” and take a community perspective. Only then would it be possible to gain a general understanding for the limitations of medical interventions.

> “Individuals can be brought to understand and accept that society might not be able to give them all they want or need. But that will be possible only if it is done in a way that shows they are not singled out for special discrimination because of who they are personally, and only if they believe that the general good of society is thereby being served.”

Callahan 1990a, p 204.

The strategy appears to be difficult to apply since it requires a broad social consensus concerning specific normative issues. It can possibly work at a more abstract level, where the discussion centres on concepts such as fairness and solidarity, but it becomes substantially more difficult as we approach more specific questions, e.g. withholding certain types of care for certain categories of citizens. It appears to be difficult, if not impossible in an open and democratic society to limit the debate to abstract values alone.

### 3.5 Model of health care requirements

According to the British health economist Joanna Coast (1996), it appears to be unrealistic, and perhaps even harmful, to choose either *rational decision making* or *pluralistic bargaining* and apply it exclusively to all areas and levels. Rational decision making (which Coast refers to as the “technical priority setting approach”) can never be comprehensive since information is often lacking and one must build on estimates and guesses, which diminishes reliability. It would be very complex and expensive to apply such a strategy on a large scale.

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\(^{21}\) Callahan (1990a) speaks in terms of needs for various groups, but does not believe that need must be established based on, e.g. epidemiological data. Rather it is about gaining acceptance in society for “reasonable” interventions within the different age groups. Generosity in caring to assure a “life with dignity” in a phase of disease, but limitations in curing by medical intervention, particularly in the elderly. Callahan also argues for prioritisation based on age in other contexts (Callahan 1987).
There are also disadvantages in *pluralistic bargaining* among different parties, according to Coast. Although this strategy may appear to be attractive in the sense that participating parties can negotiate a solution that everyone can support, it lacks a clear way (apparently with regard to principles) to assess the implemented priorities. Furthermore, the strategy offers no real incentives to use available information or to develop better information.

Using the inherent strengths in both of these strategies appears to be the best solution, suggests Coast. Considering health services at large, accessibility to information is better in some segments than in others (i.e. information about needs, costs, and benefits). This mainly concerns information for choosing among options *within* disease groups and disease areas. There is usually insufficient information to choose, e.g. between disease areas, and hence such decisions are less suited to a rational process. The same applies to choices at the individual level, where data are insufficient to take heterogeneity among individuals into account. Therefore, it appears that the rational method is not applicable even here.

Coast (1996) proposes that the full potential of rational decision making is applied in prioritising within disease groups and among treatments. However, some degree of pluralistic bargaining is also needed since knowledge concerning the goals is incomplete. At the levels involving choices among disease areas, and at the individual level, she claims that prioritisation must be based on open debate in a political process.

The *model of health care requirements* developed by Coast draws on key elements in the *rational decision making* strategy and *pluralistic bargaining* strategy. The former acknowledges the need for clear goals and principles and the latter acknowledges that priorities must be set continuously at different levels and consider the viewpoints of lay persons (consultation of patients and the public). To solve the dilemma of reaching a suitable balance between equity and efficiency – a classical problem in rational decision making – Coast suggests that both principles should be applied. Their respective roles are established through a consensus method (rather than through any particular rational method, which she dismisses). The principle of equity involves equal treatment for equal needs. It is based on knowledge about the disease (prevalence and incidence) and knowledge about the effects of medical intervention (effectiveness). Concerning the principle of “efficiency”, in this case Coast refers to *cost effectiveness* that combines available cost information with measures of utility. Views are obtained from patients and the public concerning the benefits and acceptance of different types of treatment.
Coast suggests that the advantage of combining different strategies is that it encourages the pursuit of knowledge – to identify gaps in knowledge and to fill these gaps through research. She summarises the characteristics of the *model of health care requirements* as follows (Coast 1996a, p 247):

- Aims to provide a framework for priority setting now, but by combining this with the research agenda, to inform methods for priority setting in the future.
- Combines the advantages of pluralistic bargaining with those of technical priority setting.
- Incorporates principles of equity (based on need) and efficiency.
- Pluralistic bargaining, within the framework proposed by health care requirements, provides a basis for priority setting at most levels.
- Pluralistic bargaining incorporates a lay viewpoint – but it is not prescriptive about the form this should take.
- Technical priority setting is directed at particular areas where there appears to be potential for change.
- Technical priority setting is based on three steps for action: consensus, literature review, and dedicated research.
- Within technical priority setting, trade-offs between principles are based on bargaining approaches.

Coast suggests four levels where prioritisation can be relevant and that include different elements of rational decision making and pluralistic bargaining.  

Rational decision making may be relevant in only limited cases – these are identified through discussions among several legitimate parties, i.e. via pluralistic bargaining. At the individual level, she refers to pluralistic bargaining between clinical staff and patients. This type of decision making should be “open” and thereby contribute to knowledge about the allocation of resources among patients.

It will take time before we can approach *rational decision making* on a large scale in priority setting within treatments and groups, according to Coast. Greater knowledge must be acquired, starting with the areas judged to be most important.

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22 The levels mentioned are: a) priority setting across whole services, e.g. mental health versus child health, b) priority setting within services, but across treatments, e.g. between hip replacement and arthroscopy in orthopaedic surgery, c) priority setting within treatments, e.g. between different types of prostate problems, and d) priority setting between individual patients, taking into account individual characteristics and preferences. (Coast 1996a, p 249)

23 It is not entirely clear what Coast (1996a, p 250) means by “joint decision making”, “open”, and “explicit”.
The extent to which pluralistic bargaining comes into the picture is impossible to determine in advance – it depends on the knowledge available. Even if good information is available, we cannot ignore the need to find a balance between different principles in each case. This should take place through a consensus process.

Coast suggests that a multidisciplinary approach like the one she proposes – based on different traditions and perspectives and which aims to improve the level of knowledge, while acknowledging the need to include values – is the only reasonable approach considering the practical experiences of priority setting.

### 3.6 Explicit and implicit decision making

Chris Ham and Angela Coulter from Great Britain (2001) discuss a strategy involving different ways of setting priorities at different levels in the health care system. Their point of departure is the situation in several countries, e.g. Great Britain and Israel. Regards the latter, studies indicating that the promise of explicit priority setting at the national political level is followed by implicit priority setting at other levels in the system (Chinitz et al 1998). Considering these experiences, Ham and Coulter consider if such a strategy might be easiest for democratic nations to adopt. At the national level, it is difficult to carry on a debate on priority setting without a tendency for the political system to take a very generous position. The debate in the media and actions by, e.g. patient organisations, increase the pressure on democratically elected bodies and make it difficult to deny coverage for new technologies from public finances. An open debate with subsequent decisions at the national level, however, results in a more “realistic”, implicit decision making process at lower levels. At these levels it is necessary to apply the full arsenal of methods to constrain pressure on care consumption.

Should this explicit/implicit approach be viewed as an independent strategy for priority setting? If so, how does it differ from that proposed by Hunter (1997) and Mechanic (1997)? The latter strategy views implicit priority setting as positive for everyone involved since it creates “stability” in the health services.
The starting point in *explicit and implicit decision making* is that politicians are forced to clearly define what should be financed – a consequence of the focus on more efficient health care – while the *implicit* process should be viewed not so much a conscious choice as a compelling condition. The transparency offered by one level serves to “protect” the implicit process that must be carried out at other levels. Or as Chinitz et al suggest:

“The myth of explicit rationing lends legitimacy to decisions made implicitly.”

**4. CONCLUDING REMARKS**

Fundamental differences can be found between the different strategies, but it is also possible to observe similarities (unexpected!). If we first address the view of *explicit priority setting* within different levels of the health care system the following picture emerges (Table 1). All of the strategies cover explicit priority setting at the macro level, even if the reason for this varies. At the micro level (or individual level), all strategies involve implicit priority setting, with some reservations for *pluralistic bargaining*. The pluralistic bargaining strategy advocates maximum transparency, but it is uncertain whether this also applies to decisions at the individual level. One might believe that the *muddling through elegantly* strategy includes transparency at the micro level – this strategy advocates “fair processes” for individual patients. However, this is more of a legal test after-the-fact (ex post facto) by individual cases, not insight into the decision making process. The point of this strategy is to give physicians and other care professionals an opportunity to set priorities at the micro level.

On the other hand, it is not certain how Callahan (1990a) intends to prevent care professionals from independently having to make priority decisions at the micro level when applying the *community approach* strategy. He views the decisions at this level as an application of *categorical standards*, but in practice it would appear to be impossible to avoid independent decision making at this level. The major differences appear at the meso level, where two strategies involve implicit priority setting while the others involve explicit priority setting. What possibly distorts the picture is David Hunter’s reasoning on transferring priority setting decisions to politically elected bodies at the regional or local level.

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24 We use the definition of explicit priority setting proposed by Liss (2002) and mentioned in section 2.6.
25 The concept of levels does not refer to a heretical structure such as national, regional, and local decision levels, but to the following: macro = health care versus other social sectors, meso = deciding among different technologies and disease areas, and micro = deciding among individuals.
He does not clearly state whether the motives and the reasoning behind prioritisation decisions should remain implicit. Possibly this is the case since the author of the *muddling through elegantly* strategy advocates assigning responsibility only after the consequences of the priority setting decisions have become known to the public.

Table 1. Overview of six prioritisation strategies and the use of explicit and implicit priority setting at different levels.

<table>
<thead>
<tr>
<th></th>
<th>Macro</th>
<th>Meso</th>
<th>Micro</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Muddling through elegantly</strong></td>
<td>explicit</td>
<td>implicit</td>
<td>implicit</td>
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<tr>
<td><strong>Rational decision making</strong></td>
<td>explicit</td>
<td>explicit</td>
<td>implicit</td>
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<tr>
<td><strong>Pluralistic bargaining</strong></td>
<td>explicit</td>
<td>explicit</td>
<td>(explicit)</td>
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<tr>
<td><strong>Community approach</strong></td>
<td>explicit</td>
<td>explicit</td>
<td>(implicit)</td>
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<tr>
<td><strong>Model of health care requirements</strong></td>
<td>explicit</td>
<td>explicit</td>
<td>implicit</td>
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<tr>
<td><strong>Explicit and implicit decision making</strong></td>
<td>explicit</td>
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Looking only at explicit priority setting, the strategies do not appear to differ substantially, except on a few points. This conclusion, however, would be entirely erroneous since substantial differences become apparent when analysing the respective strategies in greater detail. This becomes obvious from looking at the diagram of the priority setting process in Section 2. How do the different strategies fit into the process? The following diagram indicates their relative positions.
Figure 3. Position of the different strategies in a schematic priority setting process.

"Community approach"  "Explicit and implicit"

Agenda setting  Policy formulation  Decision making  Implementation

"Rational decision making"  "Muddling through elegantly"

"Health care requirements"  "Pluralistic bargaining"

Figure 3 shows that the six strategies emphasise different aspects of the prioritisation process. Some emphasise the importance of fundamental *values and goals* at an early stage (*community approach* and *rational decision making*) before the process moves toward collecting scientific evidence for decision making (*rational decision making*). One strategy involves developing a widely accepted decision making process before the decision is reached (ex ante agreement) and where it should be also possible to question the collection of information – a process that is repeated time and again (*pluralistic bargaining*). Some strategies emphasise the importance of a “fair process” after-the-fact, where individuals can have their specific case reviewed and the outcome of the prioritisation process judged retrospectively – ex post justification – (*muddling through elegantly*). Finally, we find a strategy where the consequences of explicit decision making at one level makes it imperative to make new decisions at another level – but this time implicitly (*explicit and implicit decision making*). In this case we have a repeated sequence where implementation presumes new decision making.

Does this mean the all strategies can be combined, since they appear to cover different aspects of the prioritisation process? The answer has to be no! The principles of some strategies are so different that this could not happen without shaking the foundation. Hence, it seems to be impossible to combine *pluralistic bargaining* with the *community approach* or with the strategy of *muddling through elegantly*. 
The *community approach* involves establishing certain principles at a general community level, whereupon they are operationalised without further community debate – members of the community are presumed to accept the consequences since they participated during the initial stages and were allowed to express their views. Mainly it is the consequences of the priorities set in the *muddling through elegantly* strategy that are openly discussed. Trying to combine these two strategies with the *pluralistic bargaining* strategy appears to be impossible since it is explicit, transparent, and open to discussion at all levels.

The *rational decision making* and *pluralistic bargaining* strategies have been presented as two opposite poles in certain contexts. To some extent this is correct, since emphasis on negotiations and policies to find possible solutions in all situations appears to be completely foreign to the proponents of the *rational decision making* approach who want to base decisions on factual information only. On the other hand, the proponents of the *pluralistic bargaining* strategy view the idea of uniform goals and perfect information to be naive or unreasonable. To the extent that the proponents of these two strategies are prepared to deviate somewhat from their standpoints, perhaps it would be possible to find a middle way like that which Coast (1996) attempts to construct in the *model of health care requirements*. Even though the proponents of *pluralistic bargaining* believe that the only possible way to set priorities is through “transparency” and “bargaining” between parties, they do not deny that better information can be developed (e.g. on the effects and benefits of technology for individuals). The proponents of the rational decision making strategy could, on the other hand, find it difficult to accept any deviation from the principle that priorities must be supported by scientific evidence. However, perhaps they could accept this if it takes place in an open democratic process, where the reasons are clearly stated, instead of in closed rooms where different constellations of power are allowed to rule freely by concealing their actual motives behind a smokescreen of words – this is actually the problem that the proponents of the *rational decision making* strategy find most difficult to accept. The proponents of these two strategies can probably find common ground in the pursuit of transparency and exposure of unverified arguments.

However, this does not mean that “fusion” is possible in all cases. The prerequisites for carrying out a priority setting process vary. It is unreasonable to view it as completely static – as a process that can be carried out independently of the environment. The rationale behind the conditions for decision making presented by Howlett and Ramesh (1995) (Section 2.3) suggests that it must be possible to vary the input from the *rational decision making* and *pluralistic bargaining* strategies, depending on time-related conditions. This, in turn, would suggest that the view on the priority setting process presented by Coast (1996) in the *model of health care requirements* is incomplete.
The availability of good evidence alone is insufficient for a “rational” approach. Conditions in the environment must also permit such a process. Otherwise, it would appear that another decision making style would be more appropriate. In other words, the priority setting process appears to be “context dependent”, i.e. the association with the environment must be allowed to influence the choice of suitable strategies, and such associations can change over time (at least it should be possible to influence some factors through active bargaining).\(^{26}\)

**Two parallel processes of priority setting?**

Our review suggests that we are not dealing with one priority setting process but with two – one involving *internal legitimacy* and the other involving *external legitimacy*. Only when we make this sharp distinction does the content of the different strategies become fully understandable.

A process of internal legitimacy aims at establishing confidence for the priorities within the health care delivery system itself – in part among the different functions, e.g. political, administrative, and clinical, and in part among those working in health care.

A process of external legitimacy aims at assuring public confidence for health care priorities. The authors of several of the strategies presented here show that external legitimacy can be established in different ways.

Two parallel processes emerge that can be linked to most of the strategies presented here. Two of these strategies appear to be compatible with a process for securing *internal legitimacy* while three mainly aim at developing the conditions for *external legitimacy* (Figure 4).

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\(^{26}\) One can imagine that the implementation of priorities at one point in time can influence the conditions for implementing priorities at a later time since the first process influences factors in the environment.
The internal legitimacy process is characterized by the ability to find a knowledge base (scientific) and arguments upon which to establish priorities. This is the only way that knowledge-based organizations such as health services can establish confidence in priority setting. The model of health care requirements developed by Coast (1996) describes a reasonable model for securing internal legitimacy for a priority setting process.\(^{27}\)

However, what Klein (1993, 1998, 2000), Callahan (1990a), Hunter (1997), and Mechanic (1997) address is a prioritization process to improve the conditions for external legitimacy. They present two fundamentally different methods: to establish confidence prospectively (ex ante) through guiding principles and an explicit, pluralistic decision making process, or to provide a retrospective (ex post) opportunity to review and adjust the outcome.

Two of the five strategies mentioned here are more likely to serve the ambition of developing a priority setting process for health care in Sweden. These include the model of health care requirements to secure internal legitimacy and the pluralistic bargaining strategy to enhance the conditions for external legitimacy.\(^{28}\)

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27 This has elements in common with a process being developed by some county councils in Sweden referred to as “Medical Policy and Action (MPA) guidelines” (medicinskt programarbete).

28 The rational decision making strategy seems to be unreasonable since the values – developed through negotiation – must, in practice, complement the process, just as Coast suggests. The community approach might appear to be attractive, but is difficult to implement in an open society, for the reasons mentioned earlier. The strategy of muddling through elegantly appears to be reasonable on many points, but it is not attractive in a democratic and open society – one “conceals” the wider context from the public, which can have unexpected effects on confidence for both the health care system and for democracy. Holm (1998)
Figure 5 shows that these two processes are, nevertheless, connected. If internal legitimacy cannot be secured, the opportunities are drastically reduced to advance toward external legitimacy. Rather, the results of the process to secure internal legitimacy within health care organizations will be used as one of several steps in a process to develop external legitimacy. A process for external legitimacy concurrently serves as “feedback” for internal legitimacy (the latter process must base its values on the former).

Figure 5. Priority Setting in Health Care – Interdependent Processes

There is a risk that all energy is expended on securing internal legitimacy while too little attention is given to developing ways to assure external legitimacy. There is also a risk that the process for internal legitimacy will be driven in the wrong direction.

There may be a danger in relying too much on the fact that health professionals enjoy (according to many studies) a high level of public trust. If the efforts to secure internal legitimacy move in a direction leading toward “unofficial professional decision making bodies” that decide on issues which are actually political in nature (should be part of the process for external legitimacy) then problems may arise. Part of the process for internal legitimacy includes being able to motivate a knowledge base for priorities.

Dismisses the idea that a “simple solution” to the prioritization dilemma in the Scandinavian environment is possible, and believes that open debate offers the only option for moving forward.
However, there are major differences between developing good decision making information based on the best possible knowledge available (where gaps in knowledge and weaknesses in methods are also discussed) and making formal decisions that have practical consequences. In the latter case, the areas of responsibility among the various health care actors – politicians, administrators, and professionals – must be clarified, as must the question of what to include in a process for external legitimacy.
REFERENCES


