Resource scarcity and priority-setting: from management to leadership in the rationing of health care?

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While continued interest in the application of priority-setting technologies is perhaps unsurprising in a time of austerity, they require sensitive implementation for their full potential benefits to be realized. This article looks at the role and value of leadership in addressing problems of a lack of perceived legitimacy and governance that have been raised in connection with the rationing enterprise. The potential and limitations of key leadership concepts such as 'sense-making' and 'framing' are explored, and notions of relational leadership and the importance of leading with political astuteness are discussed.

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A combination of economic pressures and increasing demands on health care budgets has resulted in a resurgence of the rationing debate (Donaldson *et al.*, 2010; Moore, 2010). Despite a burgeoning generic literature on health care leadership, prescriptions for explicit rationing ('priority-setting') have almost completely ignored the leadership dimension, focusing instead on decision-making algorithms and/or processes (Williams, 1998; Daniels and Sabin, 2008). Thus while 'better leadership is seen as central to improving the quality of health care and the improvement of organizational processes' (Hartley and Benington, 2010), a literature review on leadership of priority-setting concluded that:

> *…there is scant empirical data describing the contributions of leadership to priority-setting…A clearer understanding of how priority-setting in health services could be improved through effective leadership therefore has not been realized* (Reeleder *et al.*, 2006, pp. 24–25).

While it is a commonplace that strong leadership will bring about significant improvements in public and social practices, the concept remains relatively under-specified and under-theorized (Bolden and Gosling, 2006).

In this article we draw on themes from a variety of leadership literatures and offer some suggestions for the development of leadership in priority-setting, with the intention of encouraging further discussion and debate. More specifically, we synthesize material from diverse existing literatures to explore how an explicit focus on the leadership of priority-setting may help resource allocators to overcome some of the barriers that they currently face. Drawing on frameworks from the wider leadership literature to map some of the key tasks and roles that such leaders will be required to perform within the complex world of rationing, the article is structured around four potentially fruitful lines of enquiry:

- Technical and relational aspects of priority-setting.
- Relational leadership.
- The framing of priority-setting as a 'wicked issue'.
- Leading with political astuteness.

The term 'rationing' usually relates to the withholding of resources to the cost of individual patients, whereas 'priority-setting' has less starkly negative connotations, referring more to populations than individuals, without directly alluding to punitive resource allocation. While some authors have retained the distinctions between these terms (for example Klein *et al.*, 1996), others such as Ham and Coulter (2000) argue that the terms 'rationing' and 'priority-setting' are, or have effectively become, interchangeable due to the convergence of their connotations. Whichever term is

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preferred, the implications are similar and involve 'the withholding of potentially beneficial health care through financial or organizational features of the health care system in question' (Norheim, 1999, p. 1426). The terms 'priority-setting' and 'rationing' are used here to refer to the processes by which resource allocation decisions are both made and implemented in health care systems. Our primary focus is on those allocating budgets for populations at local levels of health care; therefore we exclude national budget setting and patient-level clinical decision-making from our analysis.

In recent years, a number of health care systems have sought to embed priority-setting within *commissioning* functions (Glasby, 2011). For example, in England, primary care trusts (PCTs) emerged as the main National Health Service (NHS) payers and therefore the primary resource allocator. PCTs are charged with 'the cycle of assessing the needs of people in an area, designing and then securing appropriate service' (Cabinet Office, 2006, p. 4). Arguably, one of the most important aspects of the commissioning cycle is the priority-setting process (see Øvretveit, 1995), and making decisions on resource allocation more explicit to local populations has become particularly important in the context of the present economic climate and future projections of levels of public spending (Appleby, 2008). In these conditions, priority-setting can no longer be considered as an add-on to broader commissioning processes but, rather, as a set of principles and practices which cut across and underpin all aspects. Yet, it is not just these local organizations that influence priority-setting. In setting priorities there are a range of influences that come through an organizational level, but which also incorporate national governmental institutions as well as the practices of individual professionals. Within the English NHS, for example, priority-setting decisions are also taken by provider organizations through formulary lists, assessment and eligibility regimes, medicines management and so on, and by other bodies discharging health and social care budgets. In recent times, the National Institute for Health and Clinical Excellence (NICE) has also played an influential role in NHS resource allocation, notably via its economic evaluations of many new treatments and interventions.

Given the range of stakeholders that have an interest and role in priority-setting, and the importance of priority-setting in terms of the allocation of health care resources, leadership is a crucial component of priority-setting. Yet leadership of priority-setting remains a relatively under-explored area of the literature, but one that we aim to investigate further in this article.

Technical and relational elements of priority-setting

In one of the few attempts to investigate leadership of priority-setting, Reeleder *et al.* (2006) reviewed the experiences and perceptions of chief executive officers of Canadian hospitals related to leadership in priority-setting. While findings suggest the continued importance of factors such as using evidence, focusing on social values and establishing processes, they also attest to the importance of an expanded skill set related to broader social and political tasks—including creating and maintaining relationships, managing networks, delegation and involving multiple stakeholders in decision-making. Much of the priority-setting literature might be described as inherently 'rationalistic' (Williams *et al.*, 2011) in its heightened concern with technical components of priority-setting processes. While Reeleder *et al.* (2006) retain such concerns, expressed through attention to processes and the use of evidence to support decisions, the majority of the leadership practices they identify concern the additional leadership tasks required in complex systems associated with the active construction of coalitions of support for programmes of change through leadership and governance—including fostering vision, creating alignment between stakeholders and mobilizing support across divergent interest groups. We consider the implications of this extended skill set in more detail below.

If it is accepted that priority-setting is typically conducted within complex and rapidly changing health care systems, it follows that this requires leadership practices embedded in a system of interdependencies at different levels within and between organizations. Indeed, there is a rich vein of literature which directly deals with the ever more complex linkages and interdependencies between statutory and non-statutory bodies involved in the design and delivery of health care services (for example Glasby and Dickinson, 2008). In these complex systems leadership can be conceptualized as a relational process; a shared and distributed function dependent on social interactions and networks of influence, in contrast to those models in which leadership is said to reside in the personality traits of a (or several) key individual(s). The logic is that due to the

complexity of organizational governance and accountability arrangements in health care systems, those leading local processes may not be able to call on sufficient formal authority in order to mandate implementation. In this context, leaders are required to use persuasion, facilitation and mediation as they seek to generate acceptance of the need for, and direction of, change (Peck and Dickinson, 2008).

A further implication of the relational model of leadership is that we cannot solely rely on individuals to lead, and ensure the effectiveness of, these processes. Consequently, the leadership practices identified by Reeleder *et al*. (2006) frame leadership as a complex adaptive exercise dependent on multiple leaders (or 'champions') of priority-setting processes, seeking common ground around which to mobilize. However, in practice, difficulties may arise with this idealized view of mobilization related to the interaction of diverse groups around contentious issues, and the consequences of relying upon multiple leaders to become responsible for aspects of processes/activities at different times. For example, the role of the clinical champion is important in this context, as is the relationship between clinical opinion and priority-setting more generally. However, full engagement of clinicians in explicit priority-setting requires resolution of a disjuncture between population-based techniques informed by probabilistic methodologies, such as health technology assessment (HTA) and programme budgeting and marginal analysis (PBMA), and more traditional deterministic reasoning as typically understood and applied by clinicians (Tenbensel, 2002). This can lead to a power struggle between clinicians and those advocating the application of techniques from population-based disciplines such as epidemiology, statistics and health economics (Hunter, 1997). The latter act as 'generic rationalists' seeking to apply standardized decision processes and principles across clinical areas in the pursuit of consistency. By contrast, clinicians traditionally operate more as 'contextual rationalists', mobilizing specific sub-areas of expertise and identifying mitigating circumstances and practices to counter unwelcome analysis (Tenbensel, 2002).

Thus, in setting priorities effectively, we cannot rely on the actions of a few individual leaders but require a more system-led and shared approach to leadership. Neither can we rely on a few techniques to bring about the effective steering of the system, but instead need to draw on a variety of approaches, some of which go beyond traditional approaches. In seeking to influence a range of stakeholders that they do not necessarily have formal power over, those charged with leading priority-setting will need to actively build coalitions and this will require them to influence the values, beliefs and actions of a diverse range of stakeholders. With this in mind we now turn to the literature on sense-making and framing.

Sense-making and framing: priority-setting as a 'wicked' problem

Making choices over the allocation of scarce health care resources is not an easy matter. Even when priority-setters agree on required changes, decisions can often be difficult to implement—and especially so when there are high levels of ambiguity and conflict between stakeholders over investment and/or disinvestment decisions (Williams, 2009). In the majority of the priority-setting literature, the problem that is being responded to is often conceptualized solely as one of resource scarcity—priority-setting and rationing are needed because there are not enough resources to provide every aspect of health and health care services that individuals and populations might want and need. However, this is just one way of looking at the problem of priority-setting and one that is heavily influenced by one of the more dominant discourses in the priority-setting arena informed by economics.

Grint (2005) argues that context is crucial in thinking about the effectiveness of leadership. An important component of context is the issue that leaders are trying to deal with. Grint argues that these 'problems' might be conceptualized in a number of different ways. In particular, he makes a distinction between 'tame' problems which relate to decisions that can be implemented in a linear, administrative fashion and more complex or 'wicked' problems that can face high resistance and conflict. Grint suggests that tame problems require managerial responses, while wicked ones require a more specific brand of leadership. What is being argued here is that problem type has implications for the nature of power (hard or soft) that needs to be applied within any given situation. According to this analysis:

- *Critical problems* require an immediate intervention with hard power and therefore demand a command response (where the role is to provide an answer).
- *Tame problems* are ones that organizations have seen before and thus have an established reaction and require a managerial response

(where the role is to organize a process).
- *Wicked problems* are pernicious social problems where the solution is unclear. They require a leadership response that deploys soft power (where the role is to ask questions).

While priority-setting has often been seen as a tame problem, and therefore decision process modelling has been seen as a way of effectively setting priorities, we argue instead that priority-setting is often more complex than this would suggest in practice. Drawing on Etzioni's (1964) typology of compliance, Grint argues that the construction of problems and the types of legitimate power and leadership styles may be thought of as set out in table 1. Table 1 suggests that different types of power are relevant in different situations, meaning that different types of leadership are necessary. Thus, if a priority-setting problem is identified as wicked, we must *lead*; if it is tame, *we* should *manage*; and, if critical, *we* should *command*. Williams *et al*. (2011) categorizes the potential barriers faced by priority-setters and which of Grint's categories of problems these fall in to. They then go on to outline the types of responses that these issues are therefore likely to require. This is set out in table 2.

As we have already suggested, one of the major limitations to the current focus in priority-setting is the tendency to frame the problem of resource scarcity as tame, hence the solution being technical (or managerial) and much of the focus of priority-setting in health care has been around the application of technical solutions and processes. However, in practice, technical solutions have struggled against the complex political and institutional realities of resource allocation in health care (Ham and Robert, 2003; Klein, 2010; Robinson *et al.*, 2011). Alternatively, if the problem of resource scarcity is framed as a wicked issue, leaders may play an important role in the construction of, and response to, resource scarcity—framing problems in this way helps generate the legitimacy and authority required for different responses.

If leadership is conceived as rendering a context persuasively and then applying an appropriate authority style, then leading priority-setting requires that followers are persuaded that the issue is critical, tame or wicked and apply the appropriate response of command, management or leadership 'in which the role of the decision-maker is to provide the answer, or organize the process or ask the question, respectively' (Grint, 2005, p. 1477). If we believe that a situation is socially constructed, then the important questions for priority-setters are around where management and leadership resources might best be applied. If, for example, a managerial approach seems sensible, then the problem should be constructed as tame; if leadership is the preferred approach, then the problem should be constructed as wicked (Grint, 2005, p. 1477). Table 3 provides scenarios that map resource allocation processes against Grint's conceptual frame of tame and wicked problems.

Sense-making can be a helpful strategy for leaders who need to persuade stakeholders of the value and legitimacy of priority-setting. Weick (1995) argues that 'Sense-making is about authoring as well as reading' (p. 7), and involves

Table 1. Grint's construction of problems and power.

Type of problem	*Critical/crisis*	*Tame*	*Wicked*
Form of authority (legitimate power)	Coercive	Calculative	Normative
Leadership style	Command	Management	Leadership

Table 2. Categorizing barriers to priority-setting by problem type.

Barrier	*Nature of problem*	*Required response*
Lack of evidence	Tame	Technical
Lack of data interpretation skills	Tame	Technical
Inadequate outcome measures	Tame	Technical
Unclear decision processes and criteria	Tame and wicked	Technical and adaptive
Lack of patient and public engagement	Tame and wicked	Technical and adaptive
Complexity of implementation of decisions	Tame and wicked	Technical and adaptive
Lack of awareness from key stakeholders	Tame and wicked	Technical and adaptive
Multiple objectives and values	Wicked	Adaptive
Lack of support from key stakeholders	Wicked	Adaptive
Unrealistic stakeholder expectations	Wicked	Adaptive

Table 3. Examples of priority-setting scenarios and management/leadership responses.

Predominantly tame	*Combined tame and wicked*	*Predominantly wicked*
When a statutory (government) mandate or guideline requires that a service should be provided (for example BCG vaccinations which protect against tuberculosis). The role of local actors is predominantly to ensure implementation of this directive.	When new or additional resources become available to budget holders and decisions need to be made in relation to which service or technology should receive this additional resource. Currently tabled bids (i.e. demand) exceed the available resource, and therefore decisions between competing claims must be made.	When budgets are substantially reduced requiring the discontinuation of some existing services, despite continued demand. Local leadership will be required in order to tackle: difficult decisions, a potentially hostile political environment, and achieving changes to complex delivery systems.

creation as much as discovery. The use of sense-making to frame issues in a certain way could help leaders to engage stakeholders in processes of priority-setting, further sense-making can be used by leaders to gain the legitimacy to act in a particular manner. Thus, the role of sense-making can be central to the construction and understanding of concepts and events within the context of health care resource allocation. Alternatively, appeal may be made to the 'wicked' nature of the problem of priority-setting, necessitating leadership. Health care stakeholders and interest groups often reject the notion that health care resources need to be rationed, while the experience of many budget holders is that the gap between demand and supply is widening. However, unless there is wide acceptance of the 'problem' that priority-setting is designed to address, local processes will not be considered legitimate. Therefore the first objective of those leading priority-setting is to seek to legitimate a programme of work. This is likely to be concerned with constructing the nature of the problem that priority-setting is intended to address, engaging and mobilizing support for the exploration and implementation of options for addressing the problem. Smircich and Morgan (1982) note that acts of leadership only become 'real' in the process of framing and defining reality for followers. Leaders are therefore either at most the primary symbolizing agents within organizations or groups (Bennis, 1994), or at least leaders and followers are co-authors (Fairhurst and Chandler, 1989; Fairhurst, 1993; Shotter, 1999).

Leadership with political astuteness

A final important theme from the wider leadership literature is that of 'leadership with political astuteness'; requiring priority-setters to engage with a range of institutions and stakeholders with differing—and potentially contested—cultures, values and beliefs (Hartley *et al.*, 2007). Douglas and Ammeter (2004, p. 537) stress that 'social and political skills are vital to managerial success', and yet research has shown that NHS managers often struggle with aspects of politics (Alimo-Metcalfe and Alban-Metcalfe, 2005). Indeed, while NHS managers scored highly on measures of decisiveness, they performed less well on accessibility and ability to resolve complex problems in health care. Other weaknesses related to those dimensions that are important to achieving change in services, including encouraging the questioning of traditional ways of working; thinking of ways of improving the organization and the services delivered; and seeking new ways of problem-solving. What the Alimo-Metcalfe and Alban-Metcalfe research suggests is that a number of functions that appear to be important to leadership of priority-setting tend to be weak, or absent, from leadership skills of health care professionals.

Hartley and Branicki (2006) argue that this is because politics is misconceived as unfair and having no place in rational management systems, and often associated with self-interested behaviour to further an individuals' career. Alternatively, politics may be seen as an important site of negotiation over the use and distribution of resources; a way of pursuing common purposes and reconciling differences; and/or a constructive means of mobilizing support for programmes of action by reconciling contrasting interests and values to co-ordinate a response focused on wider goals (Hartley and Branicki, 2006, pp. 6–7). If leadership with political astuteness is about dealing with contestation over ends and means in order to create sufficient consensus to achieve goals, this has clear implications for those involved in managing priority-setting. If it is accepted that priority-setting is a wicked problem and that local processes are subject to a number of outside influences, it follows that local leaders ought to develop and exercise

political skills and acumen. According to Hartley *et al*. (2007), the situations which require the skills of leadership with political astuteness include:

- Shaping key priorities within the organization.
- Building partnerships with external partners.
- Promoting the reputation of the organization.
- Managing risk for the organization.

The implication is that priority-setting leaders need to seek to gain legitimacy *internally* within their organizations, and *externally* with wider health economy stakeholders and broader civil society (i.e. due consideration is required of broader institutional, political and moral dimensions related health care decision-making). On this basis, Hartley and colleagues put forward a framework for leadership with political astuteness which suggests the skills which individuals require for leading priority-setting (see figure 1). The different dimensions are interconnected and we might think of these operating at a micro to macro-level, with skills 1 and 2 at a more individualistic level than skills 4 and 5.

Figure 1. Framework for leadership with political astuteness (Hartley *et al*., 2007, pp. 28–30).

1 **Personal skills**—individuals needs to be proactive, self-aware of their motives and behaviours and able to exercise self-control. Individuals must be open to the views of others and initiate actions rather than waiting for things to happen. Personal integrity is crucial to the actions of political leaders.

2 **Interpersonal skills**—individuals need to be able to influence the thinking and behaviour of others, particularly gaining buy-in from those that the person has no direct control over. These do not just involve 'soft' skills but also 'tough' ones as well. Leaders need to be able to handle conflict as well as coaching and mentoring individuals to develop their own political sensitivities and skills further.

3 **Reading people and situations**—this is an analytical function and involves understanding the standpoints and values of a range of different stakeholders. It requires thinking about these positions in advance and then dealing with these by drawing on wider knowledge of institutions and social systems to think about what might happen. This is the facet that deals with power and interest groups and their roles within debates.

4 **Building alignment and alliances**—this is a crucial skill in terms of action. This concerns how leaders build alliances between stakeholders who might have a wide range of different values and aims. This involves having tough negotiation skills and being able to bring differences out into the open and then to be able to deal with these and negotiate these in practice.

5 **Strategic direction and scanning**—this relates to purpose and thinking through which issues are important in terms of the future and also how these might impact in practice. So this is more than just horizon scanning and related to scenario planning and thinking through all the possible options with any one scenario.

Discussion

The sense-making and leadership with political astuteness dimensions of priority-setting considered in this article suggest a broader range of issues for the practice of priority-setting than those typically addressed in the academic literature. These include the potential for active engagement in framing options, the skills required for mobilizing support, and the perceived legitimacy of decisions. It should be noted, however, that normative claims for the importance of sense-making and coalition-building are open to challenge. Indeed, assumptions over the nature of leadership will inevitably influence the content of all prescriptions for leading priority-setting and result in competing advice. While sense-making implies active intervention in the management of meaning to inform action, leaders face two challenges which impose practical limits on the agency that they can exercise.

The first relates to the existence of rival institutional expectations which set limits on behaviour, those 'norms of appropriateness' which need to be followed in order for behaviour to be considered legitimate. If the performative nature of social life is accepted, i.e. the requirement for individuals to embody iterative instantiations of expected behaviour—the scope for leaders to construct new frames is limited by pre-existing frames, and interest groups committed to an existing frame may mobilize against a new one (see Peck *et al.*, 2009). While frames can be a resource for new behaviours by providing context and a link with pre-existing ways of seeing problems, they can also constrain them by precluding certain sorts of actions.

The second practical limit on sense-making behaviour follows from the disciplinary effect (Foucault, 1977) of the requirement for leaders to maintain a viable identity as a 'leader'. The fear of abjection faces all (would-be) leaders operating at the margins of institutional expectations (Ford *et al.*, 2008), and serves to limit their actions.

In the context of framing, Grint (2005) draws attention to the constitutive nature of distinctions between the type of problem faced, and thus by implication the appropriate leadership style. Clearly, in seeking to legitimate a given response, leaders are required to make a successful attribution of the nature of the problems they face as tame, wicked or somewhere on a continuum between the two—and thus whether coercive, calculative or normative criteria should apply to the legitimate exercise of power. Similarly, optimism over the possibility and desirability of consensus-building

may be challenged on the grounds that apparent consensus may mask inequities. Indeed the appearance of consensus may be strongest where powerful groups are able to impose an interpretation of events which masks systemic inequalities to such an extent that others are not aware of their exploitation (Lukes, 2005).

Conclusions

Although leadership is a potentially important component of priority-setting there is, as yet, little written about this topic. While much priority-setting literature treats it as a tame problem suited to technical management solutions, we have considered the implications of a range of discursive leadership fields for priority-setting activity, critically assessing the potential (and limitations) of relational leadership, sense-making and framing, political dimensions and leadership styles. Thus while we recognize the limits to our normative claims and the basis on which they may face challenge, we also recognize that these skills and orientations that are not embedded in current health care management roles, and we must avoid naïve assumptions as to the extent of autonomy afforded to leaders of local processes. In other words, if explicit priority-setting is to be granted the status of a legitimate management practice, leaders will require support. The extent to which they can engender this support by adopting the strategies outlined in this article remains open to question as this is an area that requires much more research, debate and exploration than is currently available within the priority-setting literature. However, there are a range of potential sources in the wider literature that may be able to speak to this area. ■

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