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PRIORITY SETTING IN AN ACUTE CARE HOSPITAL IN ARGENTINA: A QUALITATIVE CASE STUDY

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Abstract: *Purpose*: To describe and evaluate priority setting in an Acute Care hospital in Argentina, using Accountability for Reasonableness, an ethical framework for fair priority setting.
Methods: Case Study involving key informant interviews and document review. Thirty respondents were identified using a snowball sampling strategy. A modified thematic approach was used in analyzing the data.
Results: Priorities are primarily determined at the Department of Health. The committee which is supposed to set priorities within the hospital was thought not to have much influence. Decisions were based on government policies and objectives, personal relationships, economic, political, historical and arbitrary reasons. Decisions at the DOH were publicized through internet; however, apart from the tenders and a general budget, details of hospital decisions were not publicized. CATA provided an accessible but ineffective forum for appeals. There were no clear mechanisms for appeals and leadership to ensure adherence to a fair process.
Conclusions: In spite of their efforts to ensure fairness, Priority setting in the study hospital did not meet all the four conditions of a fair process. Policy discussions on improving legitimacy and fairness provided an opportunity for improving fairness in the hospital and Accountability for Reasonableness might be a useful framework for analysis and for identifying and improving strategies.

Key words: priority setting, Argentina, hospital, fairness, accountability for reasonableness

DISTRIBUCIÓN PRIORITARIA EN UN HOSPITAL DE CUIDADOS INTENSIVOS EN ARGENTINA. ESTUDIO CUALITATIVO DE UN CASO

Resumen: *Propósito*: Describir y evaluar el establecimiento de prioridades en un hospital de cuidados intensivos en Argentina, empleando la Administración Razonable como marco ético para una justa asignación.
Métodos: Estudio de un Caso que incluía entrevistas a un informante y revisión de documentos. Se identificó a treinta participantes empleando la estrategia de muestras tipo "bola de nieve". Al analizar los datos, se empleó un enfoque temático modificado.
Resultados: Las prioridades se determinan principalmente en el Departamento de Salud. El comité que, se supone, debe establecer las prioridades dentro del hospital no tiene mayor influencia. Las decisiones se basan en políticas y objetivos gubernamentales, relaciones personales, razones económicas, políticas, históricas e, incluso, arbitrarias. Las decisiones del Departamento de Salud se publicitan a través de Internet; sin embargo, fuera de las propuestas y del presupuesto general, no se publicitan las decisiones del hospital. CATA proporciona un foro accesible pero ineficaz para apelar. No existen mecanismos claros para apelar ni para un liderazgo que asegure un proceso justo.
Conclusiones: A pesar de los esfuerzos por asegurar la equidad, el establecimiento de prioridades del hospital no cumple las cuatro condiciones de un proceso justo. Las discusiones acerca de políticas de mejoramiento, legitimidad y equidad dan oportunidad para mejorar la equidad en el hospital, y el marco ético "Administración Razonable" podría constituir un marco útil para el análisis así como para identificar y mejorar las estrategias.

Palabras clave: establecimiento de prioridades, Argentina, hospital, equidad, Administración Razonable

DISTRIBUIÇÃO PRIORITÁRIA EM UM HOSPITAL DE CUIDADOS INTENSIVOS NA ARGENTINA. ESTUDO QUALITATIVO DE UM CASO

Resumo: *Propósito*: Descrever e avaliar o estabelecimento de prioridades em um hospital de cuidados intensivos na Argentina, empregando a Administração Razoável como marco ético para uma justa destinação de recursos.
Métodos: Estudo de um caso que incluía entrevistas a um informante e revisão de documentos. Foram identificados trinta participantes empregando a estratégia de amostras tipo bola de neve. Ao analisar os dados, se empregou um enfoque temático modificado.
Resultados: As prioridades são determinadas principalmente no Departamento de Saúde. O comitê que, se supõe, deve estabelecer as prioridades dentro do hospital não tem maior influência. As decisões se baseiam em políticas e objetivos governamentais, relações pessoais, razões econômicas, políticas, históricas e, inclusive, arbitrárias. As decisões do Departamento de Saúde são divulgadas por meio da Internet; no entanto, além das propostas e do orçamento geral, não se divulgam as decisões do hospital. CATA proporciona uma instância acessível, porém ineficaz para apelar. Não existem mecanismos claros para apelar nem para uma liderança que assegure um processo justo.
Conclusões: Apesar dos esforços para assegurar a equidade, o estabelecimento de prioridades do hospital não cumpre as quatro condições de um processo justo. As discussões sobre políticas de melhoria, legitimidade e equidade dão oportunidade para melhorar a equidade no hospital e no marco ético "Administração Razoável" poderia constituir um marco útil para a análise assim como para identificar e melhorar as estratégias.

Palavras-chave: estabelecimento de prioridades, Argentina, hospital, equidade, Administração Razoável.

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1. Introduction

Priority setting in Latin America has become one of the most discussed issues within the government and among public administration scholars, especially because of the sweeping health system reforms across the region*(1)*. The economic crisis experienced by Argentina in December 2001 transformed a nation once regarded as an economic success guided by democratic stability into a state marred by financial collapse, corruption and descent into the deepest depression in its history. Public administration has been profoundly influenced by this rupture in the nation's economic, political and social fabric. Consequently, policy making has become too personalistic, too political and too unregulated*(2-5)*.

To address these challenges within the health sector the newest wave of scholarly work in priority setting in Argentina stresses the necessity of evidence-based decision as seen in the national conference proceedings on health economics and national health policy in 2003*(6)*. This emphasis has changed significantly since the 2000 health and economics conference, which focused on health outcomes and equity*(7)*. More recently, academics and policy makers are demanding an investment in better evidence-gathering and information systems, stressing the significance of evaluating the cost-effectiveness of health interventions*(8-11)*. In addition, there has been a discussion of the necessary administrative and management technologies required to guide complex decision making essential in today's urban hospitals*(4,12)*.

Argentina's policy making evolution is following the same path other Northern nations did in the 1990s, when policy makers adopted an approach that focused on tools and evidence. This approach was thought to be insufficient to guide priority setting decisions because it only emphasized a narrow range of values (i.e. benefit and efficiency) and not the full range of values that are relevant to priority setting decisions*(13)*. Regarding such technical approaches, Holm (2000) decided it was time to say "Goodbye to the simple solutions"*(14)*. Priority setting is a value-laden process which lacks an overarching moral theory, and a technical approach cannot resolve the conflicts between competing relevant values. Consequently, there has been an increased interest in fair procedures that would allow the full range of values to be considered in an inclusive, transparent and responsive approach*(1,15)*.

While the demand for the democratization of decision-making is not new in the region, the acute national inequities experienced as a result of the economic crisis, in addition to international pressures, has increased the interest in establishing fair priority setting processes. The vast majority of literature on priority setting in post-crisis Argentina focuses on new management strategies, new health policy agendas and emphasizes consensus-seeking, fair processes and the guiding role of evidence*(1,3,6)*. Since 2001, community health centers, particularly those in the lower income neighborhoods in Buenos Aires, have gradually introduced participatory budgeting processes. However, hospital budgeting processes have not followed their example. Moreover, there aren't any studies describing and evaluating priority setting in Argentina's hospitals.

This paper describes priority setting in an acute care municipal level public hospital in Buenos Aires, examines how closely current practice at a leading public hospital reflects the academic and policy discourse and evaluates the priority setting process using an ethical framework for fair processes.

2. Methods

Design: This research used qualitative case study methods, the appropriate method considering the complexity of Argentina's context and the fluid nature of the social interactions that are fundamental to priority setting.

Setting: We studied Fernandez Hospital, an acute care tertiary level hospital with 350 beds, a staff of 1700 and 1200 daily consultations. It is one of 33 public hospitals directed by the Secretaría de Salud, or Department of Health (DoH) of the Capital District of Buenos Aires. This Hospital was purposely selected for its comparability to similar case studies being conducted in other low and middle income countries*(16)*.

Sampling: Theoretical and snowball sampling techniques were employed. Initial respondents were recommended by the hospital management as having a key role in priority setting, and these participants identified subsequent respondents. Additional respondents were selected, with the purpose of achieving a variety of views from different departments. Since the budget for the hospitals was reviewed and approved by the Department of Health, respondents were also interviewed at ministry level. In total, 30 interviews

were conducted. Nine doctors, each from a different department, 3 nurses, 3 medical directors and 3 financial administrators, 2 academics, 4 ministerial staff, including 2 deputy ministers of health of Buenos Aires, 4 members of international non-governmental organizations, and 1 politician.

Data Collection: three sources provided the data set: relevant documents, field observation and interviews. (i) *Documents* such as hospital and ministry budgets were reviewed. These were identified by hospital management and ministerial staff. Access to documents was necessary if they became relevant for the emerging themes and helped to validate the interview data. (ii) *Observations* of hospital, ministry and public settings were incorporated into the analysis when relevant. Observation of meetings within the hospital were not allowed. Extensive field notes were taken by the primary investigator (HG). (iii*) Interviews* were semi-structured using open-ended questions, and themes were pursued as they emerged. The interviews were guided by a questionnaire grounded in the conceptual framework- Accountability for Reasonableness, which has been used in many other North American and international contexts*(16-21)*. Most of the interviews were conducted with both the principal investigator and a trained research assistant, in order to facilitate interviewing in Spanish. Interviews were audio-recorded with the respondents' permission. Only one respondent refused to be recorded.

Data Analysis: Audio-recorded interviews were transcribed in Spanish. All data were read and coded for recurring concepts. Similar concepts were grouped together under thematic categories. Categories were constantly compared and organized into over-arching themes.

Conceptual Framework: 'Accountability for Reasonableness' was used as a framework for analysis*(22)*. This is an ethical framework for legitimate and fair priority setting with four conditions: decisions are based on explicit rationales that stakeholders consider relevant to the context; decisions and reasons are publicly accessible and decision making is transparent; there are explicit revision mechanisms and active leadership to ensure that the first three conditions are met.

Research Ethics: The research was approved by the University of Toronto Research Ethics Board and by the hospital's ethics board. All participants provided written consent before the interview to audio record the interviews. Data were kept confidentially and all interviews were kept anonymous.

3. Results

According to our respondents, priority setting in hospitals within the public health care system two prominent decision-making corps influence: a committee within the hospital –*Comité Asesor Técnico Administrativo* (CATA)– and the DoH, a government corps overseeing the operation of 33 public hospitals within the capital district of Buenos Aires.

This section will describe the nature of these two decision-making entities from participants' perspective, including 1) the main players and their roles in the priority setting process; 2) the rationales considered; 3) publicity; 4) revisions or appeals mechanisms; and 5) enforcement/leadership. Verbatim quotes from participants are included to help illustrate key points.

The Main Players and their Roles

All study respondents consistently reported that in Buenos Aires all *important* decision making occurs at the DoH. Annual budgetary reviews are conducted by the DoH which meets with each hospital to discuss its needs. The budget is initially reviewed and adjusted by hospital management and presented to the DoH for approval. The DoH is responsible for supplies' purchasing and the allocation of equipment and staff. One half of all supplies comes from Central Purchasing –a purchasing system serving all municipal public hospitals– managed by the DoH. Most of the hospital's budget (65%-70%) is alloted to human resources. Salaries, hiring, promoting and transferring are managed at the district's level and strongly influenced by a unionized environment. As one of the respondent explains:

> *"The Hospital does not manage Human Resources policy; it does not manage salaries, it does not manage economic incentives. Neither does it decide if a person should retire or stay 5 more years. This depends on the DoH. Conclusion: The management of the Hospital does not manage 66% of the budget. This leaves only 34%. Of this percentage there are providers, that is to say, tertiary services: kitchen, laundry, maintenance, cleaning, security. These tertiary services are for all hospitals administered from a central level….. This leaves 20% of the budget to manage, and this*

percentage corresponds to supplies: medication, disposable items, etc. A part of these supplies is obtained by centralized purchasing (at the DoH). At the central level they buy syringes and serum for the 33 hospitals. They ask us the quantity of syringes that we need, but they decide the quality of the syringes they send us. When a patient screams, we find out that the needle doesn't perforate the skin. This is the situation. Conclusion: The Hospital management only manages 10% of its budget."

CATA consists of approximately 20 persons, (including heads of departments, Municipal Doctors Association, Union Representatives, Medical Directors, and the hospital administrators) and is chaired by the hospital director. They meet weekly for deliberation among major stakeholders. Participation in CATA meetings depends on what is going to be decided hence, not all representatives are required to be present at all meetings. Many hospital's decisions are said to be made at CATA's meetings. An informant from the DoH described their perception of CATA:

"CATA is composed by all the services' heads. Its function is to discuss inside the hospital what it is going to buy and what not, which is the hospital's aim , and which isn't, on the basis of health policy…"

Departmental heads present their priority needs for supplies or equipment and additional staff to CATA, which presents it to the DoH. CATA also acts as a forum to announce decisions made by the hospital management. Respondents from the hospital management described CATA as a forum for each department to present their needs, explaining that democracy and consensus are these meetings'goals. However, if that is not considered achievable by management, the Director decides by himself. Hence, CATA's types of decisions seemed unclear.

For example, one respondent stressed that *"when decisions involve money we take decisions –Only us and the medical directors. No one else".*

Some medical staff, on the other hand, stated that CATA meets *"when there was a very important decision."* However, another physician, in frustration said, "*they meet, and they meet, but they have never solved anythin*g for me." An administrator describing CATA's functions and challenges pointed out the tension felt between the demands of the hospital and the inability for management to respond to them.

CATA is "a permanent monitor of the budget, negotiation between areas (within the hospital). We explain to certain services that we can't continue with the broken respirators: they have to be fixed. Or this is the year of the "grupo electrógeno", or of the dentistry examining rooms, because the cushions don't work anymore. In general, everybody wants something, and the majority have good intentions. Some, not so much. But this is an organization, and you can't satisfy everybody's requirements".

Requests for human resources from the DoH do not pass through CATA. The director of the hospital explained *"If I need nurses, I need nurses. I don't need to ask anyone if I need nurses at the hospital".*

On the other hand, the staff members thought that participation in CATA was exclusive -- they did not understand how resources were distributed among departments within the hospital, nor did they expect to. Inquiries made by researchers around this issue often elicited confusion or even blank responses. Hence, while democracy and inclusiveness may be desirable, decisions made by CATA are often non-participatory.

"It depends on the personal style of each hospital director… There isn't a participatory nor negotiated budget. Basically, it is up to the director of the hospital: the relationship is absolutely hierarchical. The department's head can ask for anything, but it is the director who decides whether to accept or deny petitions".

Since the DoH controls most of the hospital's budget, its management is ill equipped to respond to local needs or to plan future spending priorities independently.

The Rationales

The most frequent reasons attributed to resource allocation decisions at both district and hospital level included: DoH's health policy and objectives, personal, economic, political, historical and 'arbitrary' reasons.

1) District's health policy and objectives

The DoH controls most of the hospitals' budgets in the district; several respondents indicated that resource

allocation followed the policies and objectives of the district-wide health network which are established at the DoH and approved by legislature.

2) Personal reasons

Most respondents thought that the reasons given at both the organizational and ministerial levels, depended upon personal relationships, within those who decided, as was indicated by an official in an international donor agency:

> *"It depends upon the personal style of each hospital director… Votes don't exist: it is a 'clientelistic' relationship between the chief of the department and the director of the hospital. There aren't norms for allocating resources".*

Many participants said that arrangements were taken among management and departments based on personal relationships and mutual benefit. A nurse stated that *"(Personal relations) is how everything is managed in Argentina, it is what we know…"* While the head of a leading department stated:

> *"I think we are too used to work in a personalized, interpersonal way. What we really want to do is to work within established structures and in a truly good and direct organization… we are very 'personalistas'. The general directors talk directly to the Secretary… If I have an opportunity to take advantage through personal relations my management benefits. It can't be that way".*

In addition, there was a feeling that departments with the most ambitious and persuasive departmental leaders were rewarded with resources, while the needs of others were ignored. As indicated by a respondent who intimated, resources were provided to *"the most insistent or persuasive rather than by real requirement".*

3) Economic reasons

According to the respondents at the DoH and by hospital administrators, resource allocation decisions should be guided by economic considerations. The DoH administrators felt that it was their responsibility to keep unchecked spending under control –there was concern about medical professionals' decisions who did not consider budgetary limitations. One of the administrators explained that they had no way of assessing the actual necessity of the requests made by the staff:

> *"(O)ne wonders if (the requests) are medical necessities, or if it is only the nurse, (derogatory local expression), who just wants me to buy nonsense… (O)ne of the most troublesome problems we have is the asymmetry of information– between doctors and economists, economists and providers, providers and doctors".*

4) *Political reasons*

Decision-making was and remains centralized. Since those who make decisions within the health care system are politically appointed, respondents thought that health care related decision-making, especially at the DOH, was determined by political and personal agendas and not by actual needs. These feelings were expressed by most of the hospital staff and health advocates.

5) *Historical reasons*

An historical budgeting system predominated throughout the health care system, especially at the DoH –budget allotments are often determined by previous years spending. As one medical director stated *"unfortunately, we do everything backwards, following events and facts. 'How much did we spend last year? Add 10% and we keep everything as usual'".* Both hospital and management were critical about lack of foresight and planning in the budgeting process.

6) Arbitrary reasons

Respondents felt that the absence of data led to arbitrary, ad hoc or intuitive decision-making, which was easily manipulated. Commenting on resource allocation at the DOH respondents said; *"much of what is requested in the budget has no justification: it lacks evidence".* Within the hospital management expressed their frustration in not having adequate informatics:

> *"Another issue is how we manage resources. They provide me with supplies, but how do you control its use. Again, there are failures in the control of stock. Considering the complexity of the system, why must we continue to manage with paper and pencil: other mechanisms of control have to be applied. The hospital should be much more computerized…"*

Due to the absence of evidence, participants thought that decisions were influenced by union whims, prestige and uninformed biases. For example, the allocation of human resources was thought to be influenced by the Ministerial and union '*whims*'. This turns the hospital

unable to acquire, discipline or dismiss staff, creating great inefficiencies in labor:

> *"(S)ince the Hospital is not descentralized, one cannot administer rewards and punishments… if I don't want someone to work here anymore, the following day he consults the union, or he addresses a political contact that works in the Department of Health".*

Furthermore, nurses and the heads of less prestigious departments claimed that resources were allocated to departments and staff that contributed to the greater *prestige of the hospital* management and to the political agendas of the Secretary of Health.

Practitioners felt that many decisions were based on *uninformed biases* of other actors in the decision-making process. Many respondents were concerned about decisions being made by administrators who lacked an understanding of medical issues, such as severity or health repercussions, as was expressed by a physician:

> *"People that make up administrative management have knowledge of a need as it is written on paper, but they do not understand the reasoning behind it; they don't understand the significance of the reason for that request… for example, for them a light bulb is worth the same as an apparatus that measures blood pressure and pulse".*

Publicity

Hospital administrators were told to put budgetary decisions publicly available, all tenders made public via internet and to send emails to all registered providers. However, no reference was made to transparency of decisions regarding the hospital's interdepartmental resources distribution:

> *"There is a lot of publicity: We (in Argentina) do our purchasing 'behind closed doors'. If I want anything I call three friends, and the budget is ready. Nevertheless, everything that requires contracting is transparent…"*

Among the staff, there is a general understanding that transparency is absent within the hospital and health care system, to the extent that such a notion was often considered foreign. Only one physician had an objection regarding the lack of transparency. She stated that:

> *"(Y)ou know through internet or simply by asking, which is the hospital's budget , but you can't ask, like I believe you should be able to, about the distribution of those resources according to each area (inside the hospital)".*

Informants from the DoH were more receptive to the idea that publicity needs to be improved and that there are increasing attempts to make information available to the public through, for example, internet and public consultations.

Revision or Appeals Mechanisms

There was a lack of clear appeal process for the staff, this situation left many frustrated and desperate. Informal appeals to decisions were taken to CATA or to the DoH, however practitioners felt that only complaints from departments that gave prestige to the hospital were considered. Many practitioners felt anger when appeals for more nursing staff or equipment both to management and DoH were repeatedly ignored. The Chiefs of some departments felt that appeals to CATA were not productive.

According to the hospital managers when their requests were either ignored or rejected they turned to the hospital foundations for equipment donations. Donations were determined by the foundation's interests and the hospital's needs. The managers considered this an opportunity to bypass the governing authority of the DoH.

Enforcement/Leadership

There were no mechanisms or leaders' initiatives, to ensure that decisions were made fairly (as defined by 'Accountability for Reasonableness').

4. Discussion

This is the first time a paper provides an empirical description of hospital priority setting within Argentina's health system, and the first evaluation of hospital priority setting employing 'Accountability for Reasonableness' in Latin America.

Overview

This study was timely in Argentina, where there is a growing awareness of a need for fairer decision-making processes. This is outlined in both ministerial (policy) level and within the academia since the 2001 crisis. For example, in 2004 the Secretary of Health published an extensive document examining the crisis of

legitimacy of decision-making in the health care system in Argentina, acknowledging a political stranglehold that has failed to reflect the values of its citizens*(6)*. However, our findings indicate that there are enormous hurdles to overcome to achieve fairer decision-making (as evaluated by Accountability for Reasonableness) within hospitals where priority setting remains highly centralized and politicized.

The Process

Democratic deliberation and value-based priority setting is desirable in Argentina as was reflected in the Argentinean Minister of Health speech when proposing health care reforms: *"…Social and political values are the basis of State-Society relations. They are the pillars on which to construct governability, consensus and the democratization of power…"(6)*. CATA is a clear attempt at achieving these procedural goals within the hospital.

Unfortunately, our respondents felt that CATA was mostly powerless to address their concerns over challenges of insufficient human resources or deficient equipment and supplies. Neither did CATA provide sufficient communication to alleviate tensions and frustrations concerning decisions, and this discouraged them from participating in the priority setting process. Loss of interest in participating in ineffective priority setting has also been documented elsewhere*(16, 21)*. Furthermore, the management of human resources at the DoH level reflected the opposite of these procedural goals, frustrating respondents at all levels with the politicization of human resource allocation and the corruption and "clientelism" that governed the allocation of resources.

The Reasons

Many social policies in Argentina announce their commitment to values such as equity and participation. The Minister of Health stated that *"Argentines can no longer limit the discussion of reform of healthcare to its financial aspects"*, and proceeded to outline the common values at political level that need to be reflected in decision-making within the health care system, including Equity, Social Justice, Citizenship, Solidarity, Plurality, Efficiency and Quality*(6)*. However, implementation of most of these values in decision making is yet to be realized, as revealed in our study findings.

Most of our respondents felt that decision making was arbitrary and not supported by relevant or defendable rationales. Staff and medical directors felt that senior management based their decisions on their personal relationships and not on medical realities; administrators felt that practitioners failed to consider resource limitations when making decisions. Respondents believed that decisions made at the DoH were dictated by political strategies and were not responsive to the needs of patients. The ill informed decision-making process within the hospital was partly blamed on the weak bioinformatics infrastructure at both the institution and DoH. This finding mirrors a similar study in Uganda and other developing countries where weak infrastructure was found to be primary barrier to improved priority setting*(16,17)*.

Publicity

We found that publicity was mainly generated by the DOH and was limited to tenders and general budget decisions within the hospital. These were not surprising findings in view of the current literature on governance in Latin America –Cunilla Grua of the Latin American Centre of Administration for Development (CLAD) discussed the necessity of transparency in public administration in order to achieve legitimacy in Latin America in her article espousing the democratization of public administration*(23)*, but there is an absence of a discussion in the policy and research literature regarding the need for increased publicity of decision-making within Argentina's health system, which was mirrored in the absence of discussion regarding the need for publicity or transparency of decisions within the hospital. However, these findings may seem controversial since transparency is emphasized in Latin America, both in the public administration policies and in the literature, as a vehicle for achieving legitimacy of decisions.

Revisions or Appeals

The concept of an appeals process was absent from policy and academic literature in Argentina. An appeals process within the hospital was said to exist through CATA, however staff expressed frustration with the process. Informal approaches were found more effective - as has been described in previous literature*(16,21)*.

Enforcement/Leadership

Hospital priority setting in Argentina may be improved by efforts to meet the conditions of fairness. In previous studies elsewhere, priority setting leadership was identified as the area most in need of improvement*(24)*.

Nevertheless, explicit and coordinated efforts are required by leaders at both the ministry and institutional level and this seems unlikely in an environment where political power holds firm, even through extreme economic crisis*(11)*. While elections may occur, the same political elites rotate positions, protecting dominant power structures. Respondents at the Ministerial level appeared to be cautiously optimistic, believing that change was possible, but would be slow coming.

To implement a fair process modeled after A4R at hospital level within Buenos Aires, a minimum of municipal support would be necessary. The public hospital within the capital city is part of a municipally directed network of health service delivery. Resources are largely controlled at city level. The introduction of this process at this time would be compatible with the state objectives of Municipal officials who have stated that 'decentralization' of decision-making regarding the use of resources to the hospital level is an objective of the current administration*(11)*.

Improvement efforts should involve iterative, ongoing improvement mechanisms guided by an explicit ethical framework*(25)*. A4R could serve to lift the veil of personal and political interests to determine the allocation of resources. Unfortunately, hospitals may not have the flexibility to implement new practice and policy at the organizational level to enforce such a decision-making structure, due to the highly centralized political control over health care delivery.

The academia in Argentina and Latin America are currently bringing many of the above challenges to the forefront, and the discussion of how to make the allocation of resources fairer is slowly being brought front into the dialogue on public administration**.** For example Cunill Grau in CLAD's recent publication discusses the need to democratize public administration in an attempt to depoliticize bureaucracy and return it to the control of its citizens to protect it from corruption*(23)*. Nonetheless, political realities and public perceptions have created enormous barriers to change. Historically Argentina has been grappling with corrupt systems of governance and weak organizations, and the recent economic crisis has sent to the public the message that nothing will change. Hence, overwhelming public apathy stands in partnership with a lack of political will as the largest roadblocks to bringing tangible reforms.

Study limitations

Our findings are limited in that they are specific to this institution and to our participants. The goal of this research was to describe and evaluate actual priority setting –generalizability was not a goal. However, there is reason to believe that the findings here are relevant to other Argentinean hospitals, and are probably relevant to priority setting in many health systems, particularly in Latin America. Also, linguistic barriers posed a challenge in interviewing. Nevertheless, both the Research Assistant (R.A) –a native of Buenos Aires– and the principal investigator attended almost all interviews together. The combined skills served to provide a unique and productive dynamic of information gathering and interpretation and may have prompted more open responses from respondents.

5. Conclusion

Fairness in priority setting is a priority for public administration in Argentina, however, the historical, political, and social context challenge the realization of this goal. Our study, which described and evaluated priority setting in a hospital, revealed that there is much room improvement if priority setting is to be fair. Within the existing policies, Argentina's health policy makers should continue to pursue implementation of effective democratization of policy making, through the development of fair process at both hospital and ministry levels. In a fairer environment, participation, transparency and information needs can be highlighted and addressed, and cost-effectiveness can be emphasized alongside other context specific relevant criteria. 'Accountability for Reasonableness' can help guide health policy makers expecting to improve fairness in their priority setting.

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